

INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION TRANSFORMATION WORK GROUP



2/8/2010

Workforce Development Task Force Final Report

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Executive Summary

In February of 2009, the Indiana Division of Mental Health and Addiction's Mental Health and Addiction Transformation Work Group had multiple discussions regarding the behavioral health workforce in Indiana. As discussions continued, a Workforce Development Task Force was created in order to examine behavioral health workforce issues and how they affect consumers and their families. Workforce is defined broadly to include all of those persons who touch consumers in the process of treatment, support and recovery. A number of participants of the Transformation Work Group volunteered to serve on this task force to take part in this critical initiative.

Shortly after the formation of the Workforce Development Task Force, House Bill 1210 was created and adopted by the General Assembly and the Governor during the 2009 spring legislative session. This legislation charged the Division of Mental Health and Addiction to establish a Workforce Development Task Force and mandated representatives from various organizations to serve on the Workforce Development Task Force and participate in this initiative. This Task Force fully met the mandate of House Bill 1210 and included 59 individuals.

Attached to this Executive Summary is the final report submitted by the Workforce Development Task Force. This report details very thorough and rich information regarding four specific priority areas related to behavioral health workforce issues. The four priority areas, along with the individual charges, are listed below:

1. Licensure, Certification and Clinical Supervision – The focus of this area was to identify specific areas of the behavioral health workforce for which specific licensure or certification should be developed; recommend strategies to accomplish needed licensure or certification, including any identified barriers; and develop recommendations to improve the quality and consistency of front-line clinical supervision in the behavioral health field.
2. Culturally Competent and Culturally Diverse Workforce – The focus of this area was to review existing studies and data to analyze the current situation regarding cultural competence and cultural diversity in the public behavioral health workforce; and to recommend specific strategies that impact both cultural competency and cultural diversity.
3. Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines – The focus of this area was to assess current training curricula and teaching methods in core disciplines; and to engage training programs in recommending ways to improve the “readiness” for students moving into the current workforce.
4. Recruitment and Retention – The focus of this area was to use current and projected workforce data to identify key professional shortage areas; and to engage key professional and training leaders in identifying ways to improve both recruitment and retention in shortage areas.

A subcommittee representing each priority area listed above was established. Each subcommittee was chaired by an expert in that particular priority area. Each chair sought Task Force members and community stakeholders to volunteer to staff their particular subcommittee. The subcommittee participants represented many different

stakeholders and leaders in behavioral health and included a diverse group of consumers, family members, and a variety of agency providers and professionals. Below is a list of those individuals who participated.

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Workforce Development Task Force Participants

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Priority Area Recommendations

Licensure, Certification and Clinical Supervision

- 1. Develop Core Competencies leading to licensure, certification and/or endorsement:**
Identify existing and develop additional Core Competencies and training for specific populations which may lead to licensure, certification and/or endorsement to assess and treat specific populations. This will involve fostering interagency, state and university collaboration to support training leading to licensure, certification and/or endorsement. Examples of this practice are Peer Recovery Specialist and Problem Gambling Training.
- 2. Develop standards for and access to clinical supervision:**
Develop core competencies, standards and training for supervisors, leading to endorsement as qualified supervisors. This includes compensating supervision such as case staffing; developing a partnership between the state and providers in order to develop training related to supervision for agencies at no or shared cost; supporting the Professional Licensing Agency in developing standards for qualified supervisors for all licensed disciplines; developing a statewide database to identify qualified supervisors to assist individuals in accessing required supervision for state licensure and/or certification; and utilizing technology to access supervision and/or consultation in areas where there are shortages.
- 3. Expand and enhance the current workforce:**
Develop a course of study for prevention including a set of core competencies to establish prevention as a profession; core competencies to integrate mental health, substance use disorders and physical health; identify skills and specialty training which add to the behavior health field and develop reimbursement opportunities such as for Physician Assistants and Pharmacists; and expand billing codes to capture current, new and different approaches for prevention and wellness.

Culturally Competent and Culturally Diverse Behavioral Health Workforce

1. Mandate cultural competency training for behavioral health professionals on an annual basis.
2. Adopt policies that promote and ensure workforce diversity.
3. Develop and continuously update a mental health and addiction workforce database to record and keep track of diversity.
4. Require each treatment center that accepts public funding to create a Cultural Competency Advisory Council with the purpose of creating a cultural competency plan that addresses trainings, recruitment, retention and cultural resources.
5. Create online resources that provide information on different cultures with respect to mental health and addiction.
6. Require mental health and addiction providers to have individuals qualified to interpret mental health and addiction medical information to limited or non-English speaking and hearing impaired consumers.
7. Continue to participate in the national advisory council on cultural competency.

Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines

1. DMHA is encouraged to continue collaborating with academic institutions and other interested parties in developing consistent evidence-based curricula and teaching methods for the growing behavioral health workforce. We encourage an approach that promotes an overall health and wellness model for mental health and addiction recovery and primary care, on a continuum from promotion and prevention through recovery. The support and development of faculty and educators is a critical area of need if workforce development is to advance.

2. DMHA is advised to develop partnerships with academic institutions, core disciplines, and other individuals and organizations, including persons in recovery, to advance health, wellness, and evidence-based practices from resource identification through translational research.
3. DMHA is encouraged to prioritize workforce development from continuing education and training of current and future professionals, from psychiatrists to recovery specialists including health, wellness, prevention, evidence-based practices ranging from infant and toddler mental health to mental health of adults.
4. DMHA is encouraged to become a leader of self-directed computer and Web based learning in which all of the health and human service workforce can continue to seek the best education and information regarding mental health and addiction information and best practice. This resource should be implemented in order to achieve positive outcomes and implement effective interventions based on the most current research evidence.
5. DMHA is encouraged to look at its overall mission and recommend that the mission be wellness focused, rather than disease and diagnosis focused.
6. DMHA is encouraged to develop partnerships locally and federally to secure funds to create more translational research.
7. Through the Annapolis Coalition, the Substance Abuse Mental Health Services Administration (SAMHSA) has endorsed core competencies for addiction counseling and urges the development of core competencies for mental health practice. Human Service Professionals, including law enforcement should be trained in competencies in mental health and addiction so that screening, brief intervention, referral and treatment can occur in all health and human service venues.

Recruitment and Retention

1. Increase understanding of, and facilitate relationships between training institutions and behavioral health employers by:
 - Further DMHA-supported study of behavioral health professional training and development in Indiana.
 - Indiana DMHA to create and maintain a common website listing all job openings for all professional types at all DMHA supported clinical centers in Indiana.
2. Expand production of needed behavioral health professionals in Indiana by:
 - Legislative action and funding allotments provided for professional educational loan repayment programs, across multiple behavioral health disciplines.
 - Legislative and/or DMHA action to allocate additional resources specifically designed to increase production of, attract, and maintain the careers of behavioral health professional leaders in rural and underserved areas in Indiana.
 - State action to support and require an increase in the number of annual psychiatry resident training slots in Indiana to 12 per year.
 - Legislative and/or DMHA action to allocate protected resources directly to behavioral health treatment centers statewide for supporting professional clinical training missions at those centers.
 - Create new mechanisms to facilitate early education and career development of behavioral health professionals from the diverse language and culture, and those that are fluent in Spanish.
3. Transform and build professional training infrastructure that matches clinical needs of mainstream populations with co-morbid conditions:
 - Ensure and eventually require cross training in addictions and mental health care for *all* behavioral health professionals and integrate licensure and certifications along mental health and substance abuse treatment lines.
 - Support a new initiative for any psychiatry training program to make fellowship training in Addictions Psychiatry mandatory for residents not otherwise committed to pursuing sub-specialty training or fellowships in other areas throughout the life span (e.g. in child, forensics, geriatrics).
 - Creation of an Indiana Dual Diagnosis Gambling Addiction Treatment Excellence Center.
 - Indiana DMHA will foster full integration, communication and collaboration between ATCs and CMHCs.

We are extremely grateful to all participants for taking time out of their schedules to participate in this very important cause. Our goal is to ensure that the time and effort utilized to research, plan, survey, collect data, interview experts, collaborate, partner, attend many meetings and every other action to bring this report to a final stage will highlight the need to improve our behavioral health workforce and the urgency to do so. To that end, it was a great honor to work with so many dedicated and professional individuals towards the common goal of promoting a recovery oriented and competent behavioral health workforce. See individual subcommittee final reports attached.

Gina R. Eckart, Director
Division of Mental Health and Addiction

Dean Michael A. Patchner, Chair
Workforce Development Task Force

Chapter 1. Recruitment and Retention Subcommittee Report

Mission Statement

The goals of the recruitment and retention subcommittee were to determine the scope of behavioral health workforce shortages in Indiana; to understand causes for these shortages; and to provide potential solutions. Toward these goals, the committee accumulated and compiled available pertinent data from various Indiana sources, and designed and conducted a Behavioral Health Workforce and Recruitment and Retention Survey of all major DMHA-supported behavioral health centers in Indiana. As reflected in the committee membership and in the work of data collection, key professional and training leaders were engaged in identifying ways to improve recruitment and retention difficulties. The resulting data and recommendations are presented in this report to the Workforce Development Task Force of the Transformation Work Group.

Subcommittee Membership	
Ann Alley	Director, Primary Care Office, Indiana State Department of Health
Craig Andler	President and Executive Director, Families Reaching for Rainbows, Inc.
Matt Brooks	Executive Director, Indiana Council of Community Mental Health Centers, Inc.
Alma Burrus	Operations Manager, Division of Mental Health and Addiction
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Stephen McCaffrey	President and CEO, Mental Health America of Indiana
Pamela McConey	Executive Director, NAMI Indiana
Joe Montgomery	MBA, MSF, Project Manager, Indiana Family and Social Services Administration
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Sharon Porter	Supervisor, Vocational Rehabilitation Services, Family and Social Services Administration
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Peggy Stephens	Superintendent and Medical Director, Madison State Hospital, Division of Mental Health and Addiction

1. Background

Among all parameters that determine the effectiveness of health care delivery, none are more important than the adequacy of size, quality, and expertise of the health provider workforce. Understanding workforce deficiencies and successfully addressing them is a key concern to Indiana health care stakeholders, including those that provide health care funding, professional training, and delivery of clinical care. Behavioral health disorders collectively: 1) represent the leading root cause of premature medical illness and death in our society; 2) are major factors in the explosive growth of societal burdens of criminal justice, and incarcerations; and 3) are primary factors responsible for poverty and homelessness endemic to our cities. Thus, understanding the adequacy and quality of the behavioral health workforce is elemental not only in improving health care in our state, but the overall well-being of our society.

There is an emerging crisis in the professional workforce involving all sectors of the behavioral health field nationwide [Hoge et al. (2009) "A National Action plan for workforce development in behavioral health" *Psychiatric Services* 60:7:883-887]. This present report provides data characterizing dimensions of this crisis in Indiana.

1.1 Scope of the Clinical Problem in Indiana and Nationally

Behavioral health diseases, and specifically substance use disorders, collectively represent the #1 root cause of general medical illness and premature death in the United States (CDC, 1995-present). Even when excluding the impact of illicit substances, nicotine addiction (dependence), a *mental disorder described in the Diagnostic and Statistical Manual for Mental Disorders-IV*, is a leading risk factor for coronary heart disease (#1 leading proximal cause of death), and cerebrovascular disease (#3 leading proximal cause of death). It also is responsible for 50% of all cancer deaths (#2 leading proximal cause of death) and is related to 90% of non-cancerous pulmonary diseases (# 4 leading cause of death). Alcohol abuse and dependence, which are also mental health disorders, are responsible for the following common and often lethal conditions: 85% cases of chronic pancreatitis, 40% esophageal varices, 47% of gastroesophageal hemorrhages, 40% of liver cirrhosis, 34% of drowning deaths, 32% of fall injuries, 42% of fire injuries, 47% of homicides and 23% of suicides (not attributed to alcohol as toxic cause of death), 48 % of all motor vehicle crashes involving drivers aged 20-44.

In a recent analysis of the causes of death (i.e. not deaths as reported by immediate cause but by underlying conditions leading to the immediate cause), reported by Mokdad et al [JAMA, 2004], the leading causes of death in America are ranked as follows:

1. Tobacco consumption
2. Poor diet/physical inactivity (obesity)
3. Alcohol consumption
4. Infections
5. Toxic agents
6. Motor vehicle accidents
7. Firearms
8. Sexual behavior
9. Illicit drug use

Considering this ranking, it is important to realize that not only do the #1, #3 and #9 causes directly reflect the impact of substance use disorders, but that many, if not all of the other causes, reflect the additional indirect impact of behavioral patterns, psychiatric or addictive disorders and their combinations. For example, in terms of

#2 (obesity): appetite is controlled by a brain region called the hypothalamus; decision making leading to eating vs. engaging in physical activity is controlled by the frontal cortex. In terms of #4 (infections) Endocarditis, HIV and Hepatitis B and C infections represent a significant fraction of this mortality; up to 1/3 of these cases are caused by I.V. drug use. In terms of #6, substantial proportions of car accidents are secondary to substance intoxication (as demonstrated by CDC data). For #7 (firearms), substantial proportions of firearm deaths, whether homicidal, suicidal, or accidental occur in the context of addictions or psychiatric conditions. For #8 (sexual behavior), impulsive sexual behavior leading to medical illness is a well-known component of several mental disorders including, but not limited to, bipolar disorder, and cluster B personality disorders and addictions.

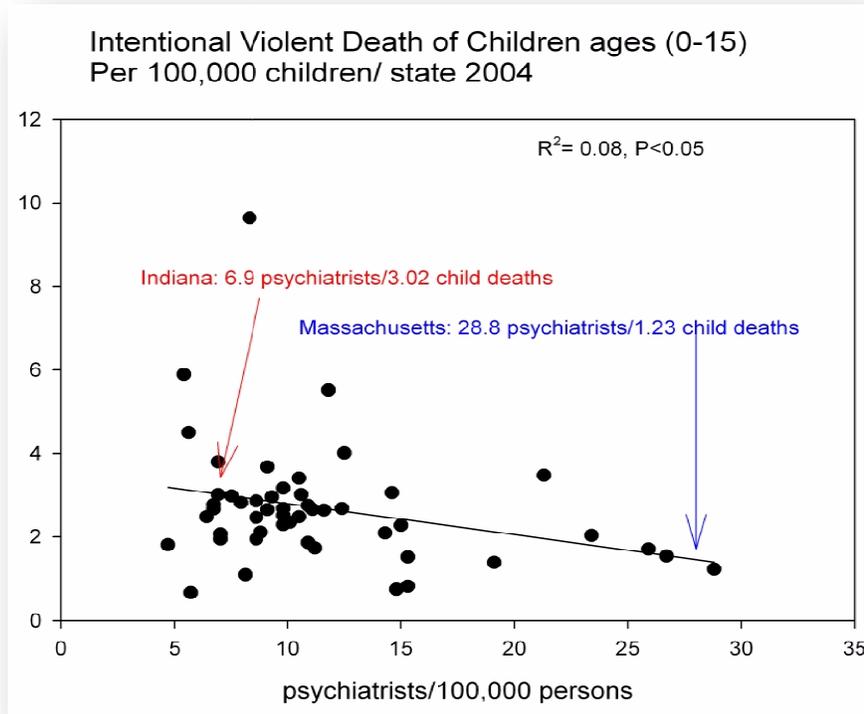
While these data depict morbidity and mortality trends due to substance disorders over the general population, an important aspect of this epidemiology is that substance disorders occur disproportionately within a minor fraction of the general population— those who also suffer with mental illnesses. In fact, mentally ill populations show two- to four-fold increases in the prevalence rates of addictions to nicotine, alcohol, cannabis, opiates, amphetamines, cocaine, and other addictive drugs. In clinical treatment settings spanning emergency rooms, outpatient clinics, hospitals, and payer sources, more than 50% of persons presenting primarily for addictions treatment have concurrent or recent history of psychiatric disorders, and more than 50% of those presenting primarily for mental health care have concurrent addictions of some kind. This major form of co-morbidity, frequently termed ‘Dual Diagnosis,’ is due to an extreme vulnerability to the addiction disease process, that is of a biological and non-volitional nature [Chambers et al, 2001 Biol psychiatry; Kessler, Biol Psychiatry, 2004; O’Brien, Biol Psychiatry, 2004]. This vulnerability is so prevalent that much of the medical illness burden, early death and public health cost-burden of addictions are disproportionately carried by populations with mental illness. For example, with respect to rates of nicotine addiction in the general population, 50% of all cigarettes are smoked by persons with minor or major psychiatric disorders [Lasser, et al, 2000 JAMA].

These data on the impact of substance disorders as the leading root cause of medical morbidity and mortality, and its high prevalence in persons with mental illness, suggests that the behavioral health workforce (including physicians (psychiatrists), psychologists, nurses, social workers, case managers, and therapists) is the most critically important component of effective public health care delivery. Indeed, since leading evidence- based treatments for either mental disorders or addictions involve delivery of both pharmacological and psychotherapeutic modalities of care working in concert, this workforce (among all those in health care delivery) is best trained for, and should be adequately deployed for, the treatment of these disorders as either stand alone or co-morbid conditions.

Several indicators suggest that deficiencies in the behavioral health workforce present in Indiana, while representative of national trends, are particularly severe. Because psychiatrists often work with or lead teams composed of many different types of behavioral health professionals, numbers of psychiatrists can serve as a proxy measure of the vitality of the entire workforce. Indiana has one of the lowest per-capita population ratios of psychiatrists in the United States, ranking at 43 in the year 2000. [USDHHS, HRSA, State Health Workforce profiles (2000)]. A useful and relatively specific indicator of the potency and vitality of the health care workforce toward maintaining a region’s behavioral health is an examination of the mortality of children due to violent-perpetrated death by parents. This measure is valuable because the killing of one’s own children is instinctually contrary to normal parental behavior and is almost always reflective of severe mental disorders and/or addictions that are not being adequately treated or addressed in the adult population. According to 2005 data from the CDC [CDC; www.cdc.gov/ncipc/wisqars], Indiana ranked #1 in the U.S. in terms of per-capita child abuse fatalities, # 1 in terms of preventable (abuse and neglect-related) related fatalities for children 0 to 1 years old, and #3 for children 0 to 4 years old. Most of these cases were perpetrated by immediate relatives and parents,

and do not include abortions or peri-delivery complications giving rise to infant mortality. When examining rates of the perpetrated death of children age 0 to 15 years old, Indiana again ranks near the top of this list. Strikingly, in a comparison of this data among all the states combined with data on the number of psychiatrists per capita in the state population, there is a significant overall inverse linear relationship (**Figure 1**: Compiled from USDHHS, HRSA, State Health Workforce profiles (2000) and CDC data (2004)).

Figure 1



Other measures suggest inadequacies of the behavior health workforce in addressing addictive disorders in the general population and specifically within mental health populations. Indiana has consistently ranked among the top five states in terms of rates of nicotine addiction [2002 data; MMWR, CDC, behind Kentucky, Alaska, South Dakota, West Virginia]. As an indirect measure of the rate of consumption of an illicit substance, Indiana has also ranked similarly with respect to the number of methamphetamine labs discovered [behind Iowa, Arkansas, North Dakota; 2004 data; National Clandestine Laboratory Database]. Meanwhile, according to estimates provided by the Indiana DMHA Task Force on Co-occurring Disorders (1999), a majority of 160,560 adults in Indiana with dual diagnoses (aged 18-24) who are living independently, receive no behavioral health treatment.

Other measures suggest inadequacies of the behavior health workforce in addressing addictive disorders in the general population and specifically within mental health populations. Indiana has consistently ranked among the top five states in terms of rates of nicotine addiction [2002 data; MMWR, CDC, behind Kentucky, Alaska, South Dakota, and West Virginia]. As an indirect measure of the rate of consumption of an illicit substance, Indiana has also ranked similarly with respect to the number of methamphetamine labs discovered [behind Iowa, Arkansas, North Dakota; 2004 data; National Clandestine Laboratory Database]. Meanwhile, according to estimates

provided by the Indiana DMHA Task Force on Co-occurring Disorders (1999), a majority of 160,560 adults in Indiana with dual diagnoses (aged 18-24) who are living independently, receive no behavioral health treatment.

1.2 Under-production of behavioral health physicians in Indiana

Despite being the only institution that trains psychiatric physicians in Indiana, and being a core clinical department within the second largest medical school in the United States, the Department of Psychiatry at the Indiana University School of Medicine is undersized in terms of full time teaching faculty and number of residents being trained. Currently, the IU psychiatry residency program graduates approximately 5-7 psychiatrists per year and from 0 to 1 per year who become psychiatric addictionologists. This is for a state of 6.3 million people, in which at least one quarter (1.5 million) will suffer some form of addictive disease with or without a treatable co-morbid mental disorder. **Table 1A** compares Indiana and Connecticut in terms of behavioral health physician workforce production and related parameters of overall public health in these states. **Table 1B** compares the IU School of Medicine and Yale University School of Medicine in terms of the number of psychiatric residency slots, and related ratios relevant to the size and mission of the medical school.

Table 1A: Psychiatric Physician Production and Related Health Care Measures

	Indiana	Connecticut
Population (2005, Census Bureau)	6.3 million	3.5 million
Number of psychiatry residency programs	1	2 (Yale + UCONN)
Number of new psychiatrists per graduating class	4-6	18-22 (Yale (14-16), UCONN (4-6))
Number of addiction psychiatrists graduating per year	0-1	2-4
Psychiatrists per capita (per 100,000)/rank (HRSA data, 2000)	6.9 (43 rd)	23.4 (4 th)
State ranking by population health (United Health Foundation, 2006)	33 rd	5 th

**State assessments of Health Care quality (encompasses all specialties)
(Commonwealth Fund report, 2007)**

Overall	38 th	7 th
Access	30 th	7 th
Quality	28 th	4 th
Avoidable hospital use/costs	33 rd	25 th
Equity	34 th	7 th
Rate of perpetrated violent death of children ages (per 100,000) (CDC 2004)	4.65	2.84

Table 1B: Psychiatric Physician Production and related medical school measures

	Indiana University SOM	Yale University SOM
Number of medical students per graduating class	275+	100
Approximate number of graduating students considering career in psychiatry	2-4 (1-2% of total)	6-8 (6-8% of total)

	Indiana University SOM	Yale University SOM
Approximate total number of Psychiatry residents at school (including years 1-4)	20-24	60
Approximate ratio psychiatry residents to medical students	0.07	0.60
Medical school rankings (U.S. News and WW 2008)	44 th	8 th

1.3 Health Professional Shortage Areas in Indiana

The U.S. Department of Health and Human Services contracts with State Health Departments nationwide to analyze local districts within states to determine shortages of primary care physicians, dentists, or mental health professionals. For mental health care, a geographic region (e.g. a county) is declared a Health Professional Shortage Area (HPSA) if one or more of the following criteria is met:

1. General population: psychiatrists >30,000:1
2. General population: Core Mental Health Providers (CMHPs) (including psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists) >9000:1
3. General population: CMHPs >6000:1 and general population: psychiatrists >20,000:1
4. Additional qualifying ratios based on poverty levels of a given region.

According to data provided by the Indiana State Department of Health, 36 of Indiana’s 92 counties and a portion of Lake County, encompassing 40% of Indiana, was designated as a Mental Health Professions shortage area in 2009.

Section Summary

Addictions and dual diagnosis disorders are the central public health concern and present as the mainstream of clinical presentations in behavioral health care. However, Indiana’s capacity to generate an adequate physician workforce in behavioral health care, as currently shouldered solely by the IU school of medicine, is deficient. Accordingly, large proportions of the state of Indiana represent health shortage areas in mental health care.

2. Rates of Turnover among Professionals

The Indiana Council of Community Mental Health Centers (ICCMHCs) conducted a Compensation and Benefits survey of CMHCs from January to April of 2009, in which 97% of Indiana CMHCs reported. This survey examined rates of compensation and annual turnover rates among various professional types in the behavioral health workforce. Compensation packages ranged considerably based on geographic region and individual role descriptions (e.g. presence of specific administrative/supervisory roles in addition to clinical line work). Summary findings from this survey are provided below:

Hourly Compensation (means)*

PROFESSIONAL TYPE/DEGREE	Geographic region of Indiana		
	Northern	Central	Southern
Psychiatrist (M.D./D.O.)	\$82	\$109	\$88
Licensed Psychologist (Ph.D.)	\$29	\$33	\$32
Licensed Social Worker (M.S.W.)	\$21	\$25	\$20

PROFESSIONAL TYPE/DEGREE	Geographic region of Indiana		
	Northern	Central	Southern
Licensed counselor (Masters)	\$20	\$22	\$26
Nurse (R.N.)	\$23	\$28	\$20
Case Manager (B.S./B.A.)	\$14	\$15	\$14
Behavioral Assistant (H.S./GED)	\$9	\$10	\$9

*lists compensation rates for part-time personnel as a gauge of comparative salary levels, independent from benefits packages that may vary widely between centers for full time staff.

Annual Employee Turnover Rates**

PROFESSIONAL GROUPING	Geographic region of Indiana		
	Northern	Central	Southern
Masters, PHDs, MDs, APRNs	15%	25%	13%
Bachelors/RN/LPNs	29%	30%	16%
Associates/H.S./GED	26%	30%	24%
Administrative (regardless of degree)	11%	20%	11%
Clerical/support staff	14%	22%	12%

**% turnover calculated as: (employees terminated during period/((employees at beginning of period)+(employees hired during period))

Section Summary

Compensation rates are generally highest in the central Indiana region which is also the most urban of regions (i.e. Indianapolis metro area). Psychiatrist salaries are comparable to that of other high need primary care physicians in short supply (e.g. general internal medicine, family medicine, pediatrics) which collectively represent the lowest paid physician specialties. In general, masters and nursing levels salaries are lower than for medical care settings or in private institutions. Consistent with findings in the recruitment and retention survey, annual turnover rates are generally higher in professional groups with lower educational attainment and in professionals not in supervisory roles. Also, the central region experiences higher turnover rates regardless of professional grouping, likely due to increased competition among employers for professionals in the urban setting (e.g. for nurses), also consistent with findings from the recruitment and retention survey.

3. Workforce Projection Data

The Indiana Department of Workforce Development has supplied occupational projections specific to several types of behavioral health professionals. Source data and modeling approaches are derived from both state and federal workforce data bases. The following table presents employment numbers in 2006 (inclusive of both public and privately employed professionals), and workforce projections a decade later (2016). The modeling and assumptions informing workforce projections are complex and tailored somewhat to each profession (e.g. incorporating economic projections, population growth projections). However, they generally indicate what will be needed if the recent status quo of current workforce densities for Indiana are to be maintained (e.g. the projections do not necessarily assume current workforce shortages).

OCCUPATIONAL TITLE	Degree	2006 employment	2016 projection	(2006-2016) new entries*	2007 annual wage**
Psychiatrists	M.D.	497	561	154	\$121,577
Psychologists	PhD	108	120	29	\$82,972
Marriage and Family Therapists	MA	407	526	200	\$37,706

OCCUPATIONAL TITLE	Degree	2006 employment	2016 projection	(2006-2016) new entries*	2007 annual wage**
Social Workers (Mental Health & Addictions)	MA	2,250	2,809	1,033	\$34,448
Mental Health Counselors	MA	1,677	2,031	332	\$34,133
Nurses***	RN	54,428	68,511	23,067	\$54,398
Addictions Counselors	BA/BS	1,016	1,264	449	\$37,399
Behavioral Health Aids/Assistants	HS/GED	772	807	104	\$23,263

*new entries needed suggests numbers of new professionals needed to enter the workforce to meet the 2016 projection, while making up for sources of attrition such as professionals moving away, retirement or death. These numbers do not necessarily account for workforce shortages or aging trends described in the other sections of this report.

** annual wages in 2007 are state median wages

***these numbers reflect the nursing workforce involved in all health care disciplines. The data base does not tease out nurses working in behavioral health; the size of this minority of the nursing workforce is unknown.

Section Summary/Interpretation

With the exception of psychiatrists, which are trained only at the IU School of Medicine in Indianapolis, the rates of production of all other behavioral health professionals in Indiana (and a listing of all institutions where they are trained) were not known by the committee at the time of this report. Notably, at a production rate of 6 new psychiatrist per year, Indiana has a current capacity to produce only 60 new psychiatrists in 10 years, or <39% of projected needs, even without accounting for current workforce shortages.

4. Summary of Findings

Converging data from various Indiana sources presented in this report suggests the emergence of a growing crisis in the behavioral health workforce in Indiana. These findings are consistent with national trends but may represent particularly severe conditions in Indiana, especially in comparison to states with larger urban populations and/or East coast regions where behavioral health care has traditionally occupied a larger ‘footprint’ within the medical treatment culture and academic training/institutions.

Although considerable portions of this report focus on the psychiatric physician workforce where workforce shortages appear particularly severe, it must be understood that the vitality of the psychiatric physician workforce is an indicator of the status of the entire behavioral health workforce, since the training infrastructures and knowledge bases that generate these professionals, and treatment systems that employ them, are interdependent among the disciplines. Accordingly, the recruitment and retention survey in Appendix B shows evidence of shortages and professional stress across all disciplines in behavioral health emerging in parallel to that occurring with respect to psychiatric physicians. In addition, data contained in this report indicate that behavioral health workforce problems are not limited only to inadequacy of size of the workforce or insufficient generation of new professionals, but also extend to the qualities and cultures of the training and clinical responsibilities of these professionals, and the systems in which they provide care. Specifically, these cultures of training and care delivery are not appropriately designed or equipped to address the clinical populations they are charged to care for because of the longstanding and pervasive division or ‘silo-ing’ of mental illness vs. addictions care lines.

Understanding the underlying causes of the behavioral health workforce crisis as a confluence of long-term dynamics occurring on both the national and state levels is important to generating new solutions. Although this report did not aim to directly explore these overarching issues, it is worthwhile to consider them briefly here as a context for which both short- and long-term recommendations may be made. To the extent that the behavioral health workforce crisis represents a view of a collapsing field, the forces driving this collapse are decades old, and may be attributed to multiple inter-related dynamics: 1) failure to understand and anticipate neurobiological vulnerability to addictions in mentally ill populations; 2) predominant societal views of drug-abuse related behavior as a moral/criminal problem rather than a biomedical disease process; 3) under-resourcing of outpatient centers to effectively engage and treat what turned out to be largely dual diagnosed outpatient populations; 4) diversion of societal funds directed to feed, clothe, house and provide health care for the mentally ill to both legal and illicit recreational drug economies; 5) vast increases in the size and cost of the criminal incarceration industry, due in part to criminalization of de-institutionalized mentally ill and/or drug abusing populations; 6) vast increases in the cost of newer psychiatric medications, significantly out of proportion to additional clinical benefits; 7) vast increases in the cost of general medical care, due to a medical treatment culture which reimburses primarily for delivery of medications and procedures, rather than professional expertise in clinical decision-making and patient contact; 8) evolution of the American medical professional training system as a market economy that preferentially supports the training of medical professionals in numbers proportional to professional income potential, rather than clinical or public health care needs.

In sum, the behavioral health workforce crisis may be viewed as symptomatic of a professional field under extreme stress, due to the explosive growth of societal resources diverted away from it, to closely related fields on its boundaries: criminal justice and general medicine. Yet, it becomes clear that a tremendous opportunity presents itself for a re-vitalization of the behavioral health field especially with respect to the integrated treatment of co-occurring mental illness and addictions, leading to more efficient, more humane, and more effective treatment of the clinical and societal problems of common interest to all of the criminal justice, behavioral health and public health fields.

5. Recommendations

Increase understanding of, and facilitate relationships between training institutions and behavioral health employers

1. Further DMHA-supported study of behavioral health professional training and development in Indiana. As comprehensively as possible, define all training and educational centers in Indiana where behavioral health workforce personnel are produced in Indiana (e.g. across all disciplines), determine recent rates of graduation of personnel from those centers entering behavioral health, obtain reports describing didactic and practical training experiences provided by these centers with respect to both mental health and addictions curriculums.
2. Indiana DMHA to create and maintain a common website listing all job openings for all professional types at all DMHA supported clinical centers in Indiana. Website should feature information provided by the centers about their communities and facilities. Indiana DMHA to identify and work with all educational and professional training institutions in Indiana to encourage newly-trained professionals to post their own candidacy descriptions on the same website.

Expand production of needed behavioral health professionals in Indiana by

3. Legislative action and funding allotments provided for professional educational loan repayment programs, across multiple behavioral health disciplines. Multiple slots are provided annually for each behavioral health professional type, and apportioned according to clinical need in Indiana. Awards should be attached to contract obligations to work at any Indiana DMHA-supported institution for a minimum of 4 years post-graduation from professional training, and repaid annually during this service. Selection of candidates for loan repayment awards to be based solely on academic achievement in undergraduate and/or professional training (e.g. not on the basis of individual financial need/training institution, or nationality). DMHA to administer this program, but appoint an independent multidisciplinary selection committee comprised of academic leaders statewide. A preliminary example of professional types and annual numbers that could be supported by this program:

--Psychiatry residents subspecialty/fellowship training in Addictions (4 positions)

--Psychiatry residents subspecialty/fellowship training in Child Psychiatry (2 positions)

--Behavioral health nurses (RNs/LPNs) (4 positions)

--Behavioral health APRNs (2 positions)

--Masters level therapists and/or social workers (6 positions)

--Behavioral health pharmacists (1 position)

--Offer one additional award for each position listed above that stipulates identification of the candidate with African American or Latino Diversity groups, and/or fluency in Spanish (up to 6 positions).

Market this programming primarily to undergraduate/professional schools within Indiana and secondarily to out of state students.

4. Legislative and/or DMHA action to allocate additional resources specifically designed to increase production of, attract, and maintain the careers of behavioral health professional leaders in rural and underserved areas in Indiana. This may include a) creation of a new faculty positions; b) creation of programming to support annual salary bonuses for new professionals that choose to serve in rural/underserved areas of Indiana; c) creation of loan repayment programs (open to all qualified candidates), requiring service at designated rural treatment centers for at least 4 years.

5. State action to support and require an increase in the number of annual psychiatry resident training slots in Indiana to 12 per year. Expand medical student training and exposure to behavioral health and addictive disorders.

6. Legislative and/or DMHA action to allocate protected resources directly to behavioral health treatment centers statewide for supporting professional clinical training missions at those centers.

7. Create new mechanisms to facilitate early education and career development of behavioral health professionals from the diverse language and culture, and those that are fluent in Spanish. For example, The Crispus Attucks Magnet School in Medical Sciences is a member of the Indianapolis Public School System and serves a relatively high density of minority students, and those of economically disadvantaged backgrounds. These

represent exactly the diverse communities from which new generations of behavioral health professionals need to be recruited from, mentored and supported in their educational development.

Transform and build professional training infrastructure that matches clinical needs of mainstream populations with co-morbid conditions

8. Ensure and eventually require cross training in addictions and mental health care for all behavioral health professionals and integrate licensure and certifications along mental health and substance abuse treatment lines.
9. Support a new initiative for any psychiatry training program to make fellowship training in Addictions Psychiatry mandatory for residents not otherwise committed to pursuing sub-specialty training or fellowships in other areas throughout the life span (e.g. in child, forensics, geriatrics). Taking this action is needed to provide adequate mental illness and addictions cross-training in new psychiatric physicians in sufficient numbers that would begin to address clinical needs state-wide.
10. Creation of an Indiana Dual Diagnosis Gambling Addiction Treatment Excellence Center.
11. Indiana DMHA will foster full integration, communication and collaboration between Addiction Treatment Centers (ATCs) and Community Mental Health Centers (CMHCs).

Chapter 2. Licensure, Certification, and Supervision Subcommittee Report

Mission Statement:

The goals of the Licensure, Certification and Supervision subcommittee were to identify specific areas of the behavioral health workforce for which specific licensure or certification should be developed; recommend strategies to accomplish needed licensure or certification including any identified barriers; and to develop recommendations to improve the quality and consistency of front line clinical supervision in the behavioral health field. The recommendations will also address the barriers and how to overcome them. The recommendations are presented in this report to the Workforce Development Task Force of the Transformation Work Group.

Subcommittee Membership	
George Brenner	LCSW, LMFT, ICACI, Director of Addiction Services, Community Health Network: Gallahue Mental Health Services Subcommittee Chair
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Angela Tomlin	PH.D., HSPP, Indiana Association for Infant and Toddler Mental Health
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Josephine Hughes	IN National Association of Social Workers
Kimberly Walton	APRN, Youth Services
Martha Levey	Peer Recovery Specialist

Summary of Activities of the Subcommittee:

The Licensure, Certification, and Clinical Supervision Sub-Committee met seven times as of October 1, 2009. Committee membership was expanded as we identified gaps and recruited those willing to serve. Primary activities of the sub-committee included identification of the range of professions and roles that make up the behavioral services workforce, determination of professions with required or optional licensure or certification, and hearing testimony from invited experts in specific areas. In recognition of the wide range of potential workers and time limitations, the sub-committee focused on those providing mental health and addiction services from the publicly funded sector. Acknowledgement and concern was expressed that many practitioners within the private, not for profit, and faith-based sides work under minimal standards and often are completely unregulated.

Across all types of workers discussed, several key themes emerged. First it was acknowledged that licensure or certification describes or recognizes a basic set of skills, but that neither informs consumers or employers about the holder's experience, competence, or capacity in subspecialty areas. Of particular concern is the client with dual diagnosis of mental health and addiction concerns, as providers were viewed as typically having skills in one or the other area, but rarely both. Shortages of providers with skills with special populations were reported, especially for the aging and early childhood populations. Attainment of subspecialty competence or expertise is typically accomplished through supervision, often post-degree. Accessing supervision can be problematic, however, since there are also shortages of professionals who typically provide supervision, whether generally or by subspecialty. Less skilled providers who may not hold a license or certification are also in need of supervision, exacerbating the shortage. Examples of these workers include Case Managers and Activities of Daily Life (ADL) Trainers. A concern was that many of the least educated workers provide the most direct services with the minimal or inadequate supervision.

The licenses speak to basic and core competencies to practice within the chosen profession. The license does not identify competence to work with specific populations. There are reports of the inability to find persons trained, competent, and willing to work with specific populations within public agencies; for example infants and toddlers, seniors, individuals who have problem gambling and addictions issues. Certifications exist for individuals that designate ability to serve specific populations yet there may be multiple certifications for the same specialty with widely different requirements. Sometimes this may be a barrier which restricts the potential workforce if certifications are required for employment. Multiple barriers and issues pertaining to supervision for these segments of the workforce were identified. There is a lack of trained workers to supervise persons in specific populations. This is often uncompensated and non-billable time thus finding persons willing to supervise with productivity expectations is an issue. The Social Worker section of the BH and HS board as well as other professions are looking at development of minimum requirements to become a supervisor. This will help future licensed persons to be adequately supervised while acquiring experiential hours for licensure. Supervisors may not be trained in evidence based practices this may be conflict with the person being supervised.

Licensed Providers:

The physicians employed within public behavioral health care agencies are mainly psychiatrists. Licensure is required in the State of Indiana. A significant shortage of available psychiatrists exists in general and more acutely in rural areas. Licensure tells us about basic competency and not about the ability to work with specific populations. There appears to be specific concern regarding working with co-occurring disorders, addictions populations, youth and more specifically infants and toddlers, and seniors. The shortage has significant implications toward supervision. Physicians often act as independent practitioners and may receive little supervision. They are

often expected to supervise other professions without the day to day experience and/or knowledge of their supervisee's roles.

Physicians in primary care medicine are a major provider of psychiatric medications and therefore a primary source for the treatment of mental illness outside of behavioral health clinical settings. They are often are inadequately trained to identify and treat those with mental illness, particularly if more chronic and acute disorders. Integrated behavioral health and physical health is receiving more attention as the standard of care. The training and supervision of primary care physicians in behavioral health is critical for this model. Not only is training and supervision inadequate for the future workforce, but lacking in the existing workforce of primary care physicians.

Licensure of nurses in Indiana covers a wide scope of practice from Licensed Practical Nurses (LPNs) to Advanced Practice Nurses (APNs) with prescriptive authority. Many of the same issues exist with psychiatrists. Too few nurses are trained in behavioral medicine or the specialty areas. Because APNs must be supervised by physicians, the physician shortage has a significant impact on the APN to meet regulatory needs.

Psychologists (HSPP), Social Workers (LSW, LCSW), Marriage and Family Therapists (LMFT), and Mental Health Counselors (LMHC) provide talk and behavioral clinical therapies to populations served in the public and private sectors. A scope of practice is defined for each license yet these may not be useful due to their vagueness and the overlap between the scope and exemptions allowed. All may provide or contribute to assessments; however, psychologists (HSPPs) are the only discipline that is able to provide psychological testing. In addition, psychologists, like physicians, may independently make mental health diagnoses using the DSM system.

The newest legislated licenses area is for Addiction Counselor and Clinical Addiction Counselors. The rules for licensure and the application process are currently under development including rules for grandpersoning. It is unknown how payers will reimburse LACs and LCACs particularly with the education requirements under grandpersoning. There are challenges for the future growth of this profession as there are few universities that currently offer curriculum to meet the licensure requirements. It is hoped through licensure, universities will see an opportunity to develop degrees that are license eligible. While supervision is addressed in the legislation, there remains a lack of qualified supervisors. As with the other professions, the licensure addresses core competencies and does not address the needs of training and supervision to treat special populations.

Clinical Pharmacists are a potential licensed specialty to add to the behavioral medicine workforce yet nearly void in the existing workforce. They are in a critical position to assist with the integration of behavioral health and physical health. With the issues related to poly-pharmacy, Clinical Pharmacists may provide significant assistance in reducing side effects, improving outcomes, and reducing costs to consumers. Barriers to this specialty becoming a viable part of the workforce include a lack of reimbursement for their services, increasing licensure standards, and limited providers with training in behavioral health.

Physicians Assistants (PAs) were also identified as a potential workforce yet are virtually non-existent in the current behavioral workforce. A license is required to practice as a PA. The license does not prepare a person necessarily to work specifically in behavioral medicine. Some of the current and future identified barriers to utilize PAs in the behavioral workforce include: extent of training in behavioral medicine, issues related to reimbursement, past restrictions on prescribing medications, hierarchy, and extensive supervision requirements for practice. Because PA's who work in behavioral medicine are virtually non-existent, supervision of those who might desire this specialty also is virtually non-existent.

Special Population

As the population ages, there will be an increasing need for professionals with competence in geriatric behavioral health. There are a number of gerontology certifications available but since there is no consistent academic curriculum these certificates provide little information about the professional's competency. Several barriers make it difficult to attract persons to gerontology such as ageism and reluctance of younger professionals to work with the elderly. Behavioral health needs of elderly individuals might be met outside of the traditional settings including: hospice; home health care; extended care facilities etc. In addition, substance abuse, misuse, and other addictions largely are not identified or treated producing significant health consequences.

The workforce for infant, children and adolescent services covers a wide spectrum of clinical types needed for a broad continuum of care. A major concern in the area of child and adolescent services is the lack of specialists in several areas, such as an insufficient supply of Board Certified Child and Adolescent Psychiatrists. This is a major concern because many primary care physicians and pediatricians are uncomfortable prescribing for children's psychiatric needs. Much as with psychiatrists, there is an insufficient supply of APRN's who are specializing in youth to help fill the prescriber gaps. With other licensed professionals such as psychologists, social workers, mental health counselors, etc. there are significant issues with a lack of persons trained to work with special populations of significant need. Some of the areas identified where little to no services exist because of a lack of trained practitioners are addictive disorders, prevention, infant and toddler mental health, and services to diverse populations including available bi-lingual services. In many cases, board recognition, certifications, and endorsements exist for some specialty areas yet lack standardization. Making these certifications a requirement for employment would place an additional restriction on the workforce. At the same time, once hired, an insufficient number of supervisors exist in these areas to train professionals in these specialty areas.

The remaining workforce for infant to youth is a diverse group including Case Managers, ADL Trainers, Mentors, Peer Recovery Specialists, and Technicians. Often job titles and descriptions differ from agency to agency making standardization difficult. There also is a variance in terms of minimum education requirements for similar positions from agency to agency. This is further complicated by the continuum of settings where these services are provided; e.g., inpatient, partial hospitalization, residential, school-based, home-based, and systems of care provision. While some minimum requirements are established or are being established by specific payers (like Medicaid), uniformity does not exist.

Over the last 10 years, Indiana has increased its awareness of infant and early childhood mental health through collaborations between state agencies (i.e., Division of Mental Health and Addiction, Indiana Department of Correction, and the Indiana State Department of Health) universities, and advocacy groups. Some of the points of emphasis in these awareness and training efforts include:

- Infants and young children experience relationship, behavioral and emotional health problems at rates that are similar to those of older children and adults (Carter, Briggs-Gowan & Davis, 2004).
- Relationship, behavioral and emotional health problems can be identified and diagnosed (Zero to Three, 2005).
- Evidence based interventions are available for the relationship, behavioral and emotional problems of infants and young children (Lieberman & Van Horn, 2005; McDonough, 1999).
- Treatment is cost effective, with savings of \$12 on the dollar spent reported (Tolan & Dodge, 2005, Rolnick & Grunewald, 2003).

Like all other areas, there are limited professionals working or available for supervision in Early Childhood Mental Health (ECMH). There are several related reasons for the dearth of ECMH providers and supervisors in the state. One, Indiana has no graduate level programs in Infant or Early Childhood Mental Health. Interested professionals would need to travel to another state or consider an online program to gain this competency. Second, unlike other states (i.e., Michigan, Florida, Arizona: MI-AIMH, 2003), Indiana has no licensure, certification, or endorsement in ECMH. Therefore, providers interested in this work have little reason to gain formal training, since it would not result in licensure or another specific designation. Third, it is unclear how the types of services considered best practices in ECMH, (such as dyadic treatments and use of diagnostic systems specific to early childhood) can be reimbursed through third party payers, including Medicaid. Finally, because of the long standing lack of providers, there also is a lack of experienced providers who can support and mentor potential new professionals. As a result, supervision is difficult to find.

Medicaid and Medicaid Rehabilitation Option (MRO) are primary payers to support the behavioral health care treatment needs of the seriously mentally ill and children/youth. Significant changes have and continue to occur in this managed care effort. The group received a presentation of a draft of proposed changes to MRO service definitions for the seriously mentally ill, children/youth, and addictions clients. The presentation had significant implications to workforce issues including licensure, certification, and supervision as the services eligible for reimbursement have specific minimum provider qualification standards. Some services eligible for reimbursement are new and require the recruitment and training of persons not previously employed in significant numbers in the existing workforce. In some cases, standards will need to be more clearly defined and developed and then subsequent training readily available.

Non-Licensed Workers:

The remaining workforce needed to treat the seriously mentally ill not previously discussed in this document represent a wide spectrum of professionals with broad minimum standards for education, training and supervision. Case Managers and Employment Specialists have a certification available and Recovery/Rehab consultants have at least 2 certifications available yet none of these are required. Peer Specialists will soon have certification available. It is unknown if a certification exists for Activities of Daily Living instructor to practice in Indiana. It is unknown if a certification exists for persons who work as staff in residential programs such as group homes and cluster apartments. Qualified Mental Health Professional is a designation for which standards are currently being developed. Although these individuals work with the most acutely ill, in many cases these workers lack formal training, and post secondary education, and frequently have the least training, supervision and support. Specifically, they often are supervised by persons who do not have firsthand experience with their day to day working.

Tied to all areas of mental health and addictions and particularly identified with youth from infancy to adolescence is the area of prevention. While viewed as an essential service with a significant investment of time and resources over the years by different departments of state government (including DMHA, a variety of institutions, and universities), prevention lacks a clear definition and reimbursement structure. Certification by Indiana Association of Prevention since 1997, four prevention certifications have been developed: Certified Prevention Professional, Qualified Prevention Professional, Associate Prevention Professional, and Trained Prevention Professional. Identified issues are a lack of standardized core competencies, no state licensure, a lack of a college or university course of study, and a lack of monitoring for required continuing education. Prevention and mental health promotion has been a significant area of investigation by a sub-committee of the TWG. A major area of discussion has been the lack of an integrated approach to substance abuse prevention and mental health

promotion leading to a significant silo effect. A more integrated approach has been recommended. This silo exists not only between the two areas identified but also between the fields of prevention and treatment. Prevention as a field and discipline is a relatively new approach and has not gained in value as a profession which challenges attracting and training the workforce in this area. Added to this challenge is the lack of recognition and value of prevention as an evidence-based curriculum, set of strategies and practice.

Indiana Certified Peer Recovery Specialist is a new credential that will be recognized in the State of Indiana and reimbursable under the Medicaid Rehab Option. This is an example of a partnership between the state, a training body, and providers that will add to the workforce. A standardized curriculum is being developed for a recognized certification to provide a specific role within the provision of care to all populations reimbursed through MRO. Although concern exists about the limited number of training slots, the partnership could serve as a template for the development of other competencies, as it will provide a low cost option to increase the workforce and the employer would know that specific training and certification was met. From a supervision point, it offers the same challenges as other licenses and certifications. There are few to no existing Certified Recovery Specialists and it is a new credential so no existing supervisors exist in this current role.

Preliminary Findings and Conclusions in no particular order of priority:

1. Licensure is valued as it reflects a set of core competencies met within a given profession. One significant limitation is that it tells us little about competency to work with specific populations.
2. Certifications, Endorsements, Boards, etc. are valued as a way of identifying additional core competencies, as training and ability to work with special populations. Some limitations are: several certifications exist for the same specialty with mixed standardization between them, some require little formal training and tell us little about the individual's competence, etc.
3. Licensure and Certification can be a potential barrier to expanding the workforce if used as a minimum standard for obtaining employment as they can be costly to obtain by an underpaid and entry level workforce.
4. There are a number of licensed professionals with important skills but largely unrepresented or virtually non-existent in the current behavioral care workforce. Barriers need to be reduced to expand these segments of the workforce including pharmacists and physician's assistants.
5. There is a lack of standard curriculums in post secondary education leading to degrees and certification in specialty areas. We are not sure where the responsibility lies to clarify this, whether it is a professional organization's responsibility, the universities responsibility to standardize curriculums, or in the supervision at the practice level.
6. The state is moving toward minimum standards for professionals who are eligible to supervise persons for specific licensure. While this is generally seen as a positive to ensure adequately trained and qualified staff through supervision, there will be an additional burden to identify and train those individuals who are eligible to supervise unlicensed staff working toward licensure.
7. There are not enough professionals in many occupational areas which leads to lack of available supervisors. This only exacerbates the problem finding competent staff trained to supervise and train individuals in the special population areas.

8. New credentials and certifications are being created to address broader range clinical needs. Since these are new, there potentially are no preceptors or supervisors for these new credentials.
9. Supervisors are often those who have been in the workforce for a period of time and not always aware of the current evidence based practices. This leads to new employees or interns being trained in conflicting models of care.
10. With reimbursement for behavioral care services in the public sector being low compared to other health procedures, there is an emphasis on productivity and billable hours. Agencies have used a variety of compensation models for professional staff based on productivity. This acts as a disincentive to supervise as it affects ones compensation.
11. Persons who work with the seriously mentally ill as with many other occupations, are some of the most under trained, under supervised, and underpaid professionals in behavioral healthcare. They are also often trained and supervised by persons who have little understanding of their day to day work. This often leads to burnout, job stress, and turnover, putting additional burden on the agency and co-workers.
12. Some agencies have to turnover as a way to downsize without termination. This may lead to a loss of experienced and credentialed staff who are largely responsible for supervision of less experienced/trained staff.
13. While there is certification within Indiana for prevention professionals there is no state licensure.
14. There is a lack of core competencies or standardized training for drug prevention.
15. There is a need for formalized training for supervisors for all disciplines.
16. Early childhood best practice such as dyadic treatments and use of diagnostic systems specific to early childhood, are difficult to be reimbursed through third party payers, including Medicaid.
17. There is a need for specified training for supervision of Peer Recovery Specialists.
18. There is a lack of a course of study for prevention as a profession.

Recommendations:

1. **Develop Core Competencies leading to licensure, certification and/or endorsement:** Identify existing and develop additional Core Competencies and training for specific populations which may lead to licensure, certification and/or endorsement to assess and treat specific populations. This will involve fostering interagency, state and university collaboration to support training leading to licensure, certification and/or endorsement. Examples of this practice are Peer Recovery Specialist and Problem Gambling Training.
2. **Develop standards for and access to clinical supervision:** Develop core competencies, standards and training for supervisors, leading to endorsement as qualified supervisors. This includes compensating supervision such as case staffing; developing a partnership between the state and providers in order to develop training related to supervision for agencies at no or shared cost; supporting the Professional Licensing Agency in developing standards for qualified supervisors for all licensed disciplines; developing a statewide database to identify qualified supervisors to assist individuals in accessing required supervision for state licensure and/or certification; and utilizing technology to access supervision and/or consultation in areas where there are shortages.

- 3. Expand and enhance the current workforce:** Develop a course of study for prevention including a set of core competencies to establish prevention as a profession; core competencies to integrate mental health, substance use disorders and physical health; identify skills and specialty training which add to the behavior health field and develop reimbursement opportunities such as for Physician Assistants and Pharmacists; and expand billing codes to capture current, new and different approaches for prevention and wellness.

Our work continues to examine licensure, certification, and supervision of other segments of the behavioral care workforce. Sometimes we have raised more questions versus created possible solutions or answers.

Chapter 3. Culturally Competent and Culturally Diverse Subcommittee Report

Mission Statement:

The goals of the Cultural Competent and Culturally Diverse subcommittee were to review existing studies and data to analyze the current situation regarding cultural competence and cultural diversity in the public behavioral health workforce. Also, this subcommittee was charged to recommend specific strategies to impact both cultural competence and cultural diversity. The resulting recommendations are presented in this report to the Workforce Development Task Force of the Transformation Work Group.

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Background:

The Division of Mental Health and Addiction in 2009 created the Workforce Development Task Force to address issues of mental health workforce in the state of Indiana. Along with three other subcommittees, the culturally competent and culturally diverse workforce subcommittee was created.

The subcommittee's charge was twofold: Review existing studies and data to analyze the current situation regarding cultural competence and cultural diversity in the public behavioral health workforce, and recommend specific strategies to impact both cultural competence and cultural diversity. The subcommittee approached its charge by first asking what is working in Indiana in regards to a culturally competent workforce. Secondly, it set out to review existing data outside of Indiana as to how other states are addressing culturally competent and culturally diverse workforce planning. Thirdly, what recommendations could impact positively a more culturally competent and culturally diverse behavioral health workforce in Indiana.

An analysis of several existing studies reveals that Indiana has made positive strides to creating a culturally competent workforce by providing cultural competent training to mental health centers and other health related organizations through the Indiana Minority Health Coalition. However, there is a need for standardized culturally competent training for mental health professionals to address the growing number of diverse groups in Indiana. The national studies show that as a country we are facing a crisis in the shortage of mental health professionals, but even more so, there is a growing disparity of bilingual mental health professionals. The national studies also reveal that Indiana must work harder to ensure a culturally competent and culturally diverse workforce due to other states' coordinated and well-planned workforce development initiatives. States such as Texas, Washington, and Connecticut are leading the way in workforce development issues.

After several months of intensive work, the culturally competent workforce subcommittee is making these recommendations to the Division of Mental Health and Addiction and the General Assembly in order to move along a process of creating a culturally competent and culturally diverse behavioral health workforce in Indiana. The recommendations of the subcommittee present practical solutions that address culturally competent behavioral health workforce disparities. The recommendations also present challenges to behavioral health systems who have not actively sought to address cultural competency and recruit and retain ethnically diverse staff. The complete list of the subcommittee's recommendations can be summarized in these broad categories:

- Mandate cultural competency training for behavioral health professionals on an annual basis.
- Adopt policies that promote and ensure workforce diversity.
- Develop and continuously update a mental health and addiction workforce database to record and keep track of diversity.
- Require each treatment center that accepts public funding to create a Cultural Competency Advisory Council with the purpose of creating a cultural competency plan that addresses trainings, recruitment, retention and cultural resources.
- Create online resources that provide information on different cultures with respect to mental health and addiction.
- Require mental health and addiction providers to have individuals qualified to interpret mental health and addiction medical information to limited or non-English speaking and hearing impaired consumers.

- Continue to participate in the national advisory council on cultural competency.

Together, we will create a stronger culturally competent and culturally diverse behavioral health workforce throughout Indiana. The people of Indiana deserve the best services provided and authorized by the Division of Mental Health and Addiction, nothing less.

Introduction

The 21st Century is upon us and we live in a rich ethnic and cultural diversity context. Along with this, about one in four adults in the U.S. suffer from a mental disorder in a given year, with about 6 percent suffering from a serious mental illness. In addition, mental disorders were one of the five most costly conditions in the US in 2006 with care expenditures totaling 35.2 billion in 1996 to 57.5 billion in 2006 (Agency for Health Research and Quality, 2009). For minority population's access to mental health services is worsening. For example, Medicaid-insured black consumers are less likely to be treated for mood disorders than their white counterparts. Hispanics and Blacks received minimally adequate treatment for mood, anxiety, impulse control disorders. While the quality of health care is improving for the nation as a whole, it is getting worse for Hispanics, especially those who speak little or no English (Agency for Health and Research Quality, 2009).

In terms of racial ethnic makeup of the U.S. between 1980 and 2000 there was a marked increase in minority populations as compared to the White non-Hispanic population. By July 1, 2004, the total population of the United States was 293.6 million with Whites (236 million), Hispanics or Latinos (41.3 million), Blacks (37.5 million), Asians (12.3 million), and American Indian and Alaska Natives (2.8 million), (US Census Bureau, 2004).

While the above data is compelling, a starting point in our understanding of a culturally competent and culturally diverse behavioral health workforce is the concept of culture. According to Gordon, culture is the way of life of multiple groups in a society and consists of prescribed ways of behaving or norms of conduct, beliefs, values, and skills (Gordon, 1978). Pinderhughes (1989) asserts that culture defines the problem perspective, the expression of the problem, the treatment provider, and the treatment options. As the Division of Mental Health and Addiction strives to have providers that are culturally competent and culturally diverse it is important to understand the culture of those who receive behavioral health services. Awareness of these cultural contextual orientations is an integral piece to understanding on how to serve persons with mental health and substance use conditions in Indiana.

According to Doman Lum, "The social context of those who suffer mental illness and oppression describes the essential elements of the individual and his or her particular environment" (Lum, 2007). Lum adds, "In order to fully understand a person, one must take into account the total context of how the texture of the person has been woven together to form a unique being. What pieces or ingredients have put together to form a mosaic or detailed pattern? What is the total context that transcends the person and the environment and must be understood for helping to proceed?" (Lum, 2007). Lum would assert that mental health professional or addictions counselor in Indiana should understand that the term context implies a "joining and weaving together" of textures that are surrounded or immediately next to parts that create how a situation, background, or environment is structured or put together (Lum, 2007). Indiana's behavioral health workforce will need to understand the social context of its consumers and the diversity groups they represent in order to offer culturally competent behavioral health services.

This report is an attempt to review existing studies and data to analyze the current situation regarding cultural competence and cultural diversity in the public behavioral health workforce in Indiana and the nation. A brief overview of Indiana behavioral health workforce and a snapshot view of other states initiatives will be discussed.

Recommendations will be presented that can potentially impact the cultural competence and cultural diversity of the behavioral health workforce in Indiana.

Our Context: Indiana

Indiana has both successes and gaps in its response to the mental health and addiction demands of its increasingly diversifying population. From the last census (2000) to 2008, the population of Indiana had grown by 4.9% becoming the 16th state with the largest population in the United States. For example, by age, in 2007 pre-school age (up to 4yrs old) comprised 7% of the population, school and college age (5 to 24 yrs) were 27%, young adults (25 to 44 yrs) were 27% and older adults and the elderly were 38%. Similarly, by race and ethnicity, while 88% of the population in 2008 was Caucasian, 12% of the population comprised of minority populations including African Americans, Multiracial, Asians, American Indians/Alaskan Natives and Native Hawaiian/Other Pacific Islanders. Also, by ethnicity, 5.2% of the population was of Hispanic/ Latino origin. (States Indiana Profile) Furthermore, while current statistics show a favorably diverse population racially and ethnically, it is projected that by 2040 minority populations in Indiana will grow exponentially – Multiracial by 240%, Hispanic by 120%, Asians by 70% and African Americans by 30% - while Caucasians will only grow by 13%. (Stats Indiana)

The cultural and linguistic competency need in mental health and addiction demand is not only predetermined by the forgoing two indicators of age and race/ethnicity, but by other differences as well that exist even within the larger cultures forming subcultures, for example, gender, poverty levels, gays and transgender populations, offender community, military veterans, and so forth. The diversity presented by Indiana's client population evokes the imperative need for cultural competence both by representation in the workforce and skills in service provision. A summary of notable successes and potential opportunities are presented below.

The Indiana Division of Mental Health and Addiction (DMHA) has undertaken significant efforts in increasing cultural competency among service providers. Notable initiatives include the DMHA Cultural Competency Project and the HIV Statewide Awareness Program. Both initiatives are statewide in scope: the DMHA cultural competency project offers 10 regional trainings on cultural competency throughout the state annually, 3 webinars on current cultural competency issues, technical assistance on cultural competency to DMHA partners and a statewide conference on cultural competence; the HIV statewide program invites guests to speak on various topics on HIV service provision which include information in understanding addictions within minority populations, in service provision to the gay/transgender communities, and overall understanding of service provision to various minority populations. Through these two initiatives DMHA has been able to provide opportunities for enhancing cultural competency to numerous providers and institutions offering mental health and addiction services.

To complement these initiatives, Indiana's DMHA has undertaken steps to transform mental health and addiction service provision throughout the state. A major focus of the transformation is ensuring participation of consumers, children and youth in the development, delivery and evaluation of mental health and addiction services. In the transformation, emphasis is given to culturally appropriate and competent service provision among others. (Indiana Disproportionality Commission, 2008)

Following the 2004 report from the Indiana Commission on Abuse and Neglected Children and Their Families, interested professionals and organizations from the public and private sectors serving in child welfare, education, juvenile justice and mental health systems formed the Indiana Disproportionality Committee (IDC). The IDC set its vision to ensure children of all races and ethnicities are equitably served by Indiana's child welfare, education, juvenile justice and mental health systems; subsequently, ensuring that issues that have resulted in minority populations being negatively overrepresented and positively underrepresented in these systems are addressed.

IDC has continuously engaged and encouraged discussions on disproportionality through focus groups, presentations at workshops and conferences and publications (e.g. “Addressing Disproportionality: A collaborative Community Approach”). Recently, IDC was funded by the Indiana Criminal Justice Institute (CJI) to conduct an assessment of cultural competency training practices within the four systems, including mental health, develop Indiana Cultural and Linguistically Appropriate Training Standards and identify elements of a curriculum for cultural competency trainings of the workforce in the four systems. Also, IDC working with Indiana’s Legislative Service provided the foundation for the Commission on Disproportionality in Youth Services.

The Indiana Commission on Disproportionality in Youth Services found that the disproportionality issue is complex and cuts across all four systems that are being considered: child welfare, juvenile justice, education and mental health. Among their findings was the establishment that child-serving professionals in all systems, including mental health, were less diverse than our population and that it was not clear whether current professionals have received sufficient cultural competency training. Both of the foregoing factors were found to result in cultural misunderstandings that lead to undiagnosed or misdiagnosed mental health challenges; consequently, triggering a cascade of events that result in disproportionality, for example, placement in settings that may be unresponsive to mental health needs such as juvenile justice system and child welfare system.

Since 2001, Northeastern Center (NEC), a well-established community mental health center in Northeast Indiana, has attempted to increase its mental health services to the Latino community in Ligonier, Indiana and surrounding counties. NEC has gone about its work with addressing the mental health needs of Latinos and worked at establishing relationships with local leaders to reduce stigma of mental health related issues through mental health promotion activities.

Bienvenido is a brief psycho-educational program developed by the Northeastern Center in Indiana under the leadership of Gilberto Pérez, Jr. has largely been directed at Latino immigrants to participate in this 9 week course. Due to the increasing growth of Latino immigrants in areas in Indiana and within the U.S. not familiar with varying Latino cultures, the Bienvenido Program presents a novel and promising intervention offering a tangible and structured format that holds promise for incorporation in other communities.

During the past 3 years, this program has been implemented with court-ordered participants and voluntary participants from various counties in Indiana such as: Allen, Elkhart, LaGrange, Laporte, Marion, and Noble to weekly evening meetings lasting about an hour. The curriculum is based on a structured set of topics, which continue ongoing information gleaned from prior recently employed strategies. The program has also been implemented in Baltimore, MD. Court ordered participants (95) have been referred to Northeastern Center for the Bienvenido Program. Of those 95: 37 successfully completed probation; 40 are still on probation and in compliance; and 17 of the 95 violated their probation after attending the program. Of that 17: 12 were for reasons other than a new offense or drug use and 5 were for new offenses (2-operating while intoxicated, 2-operator never licensed (driving and never having a license), and 1-battery to a person under 12 yrs old and domestic battery. Out of the 95 people ordered, only 4 have committed new offenses since being released from probation. Those offenses are 2-OWI and 2-Operator Never Licensed. Judge Michael J. Kramer, Noble County Superior Court 2 writes,

“It has been a pleasure for our court to have received the services of the Bienvenido Program, which greatly benefit those who appear before the court for several years. Since we began offering the program, I see fewer repeat offenders in criminal cases. I believe this is due to the bridging the cultural divide that often separates new immigrants. Without Bienvenido too often the learning of cultural norms in the United States was a difficult process.”

Northeastern Center has developed a mechanism to address the lack thereof of a workforce by creating a mental health facilitator training initiative. Northeastern Center has trained 145 individuals and mental health professionals from Indiana including California, Maryland, and Michigan in the Bienvenido curriculum. The mental health facilitator utilizes the Bienvenido curriculum, a Spanish language-teaching tool each class session. The curriculum offers the facilitator an array of teaching tools such as effective group management, facilitator roles, and learning styles. The Bienvenido Program and its curriculum is novel in that facilitators who deliver the material are instructing Latino immigrants on topics of acculturative stress and mental health needs, and building relationships with Latino immigrants who would not otherwise have had contact with this type of educational material. In essence, the Bienvenido curriculum has become a dual vehicle to build facilitator knowledge and enhance protective factors in the Latino immigrant.

In 2007 the mental health promotion program, Bienvenido, was evaluated by Dr. Delia Saldaña, Ph.D. University of Texas Health Science Center, San Antonio, TX. The evaluation sheds new light on the impact of a preventive mental health intervention (Bienvenido Program) with Latino immigrants. Examination of the data indicates that participants changed in a positive manner in increased understanding about mental illness and handle stress better. Dr. Saldaña writes,

“One of the outstanding strengths of this program is its reliance on community networking and team building. This endorsement of “it’s our community” is an innovative and rare approach to responding to addressing individuals with emotional or behavioral problems. The second distinctive characteristic of this rehabilitative program is to treat participants not as stigmatized and monitored individuals who were referred to this “treatment” program, but rather as a group of people who have the choice of recognizing and using their strengths that can contribute to a better community. While male clients are typically referred for drug-related misdemeanors, heavy emphasis is placed immediately on recognizing individual indigenous identity, heritage, values and the impact of acculturation and Latino status in a primarily Caucasian community. Many acculturative stresses are addressed that contribute to substance abuse or its consequences such as domestic violence, social isolation, academic risks for their children, and fragmented access to healthier supports that could potentially be quite useful.”

The Bienvenido Program has also partnered with various Latino and minority health coalitions such as Hispanic/Latino Health Coalition of Elkhart County, Laporte Minority Health Coalition, Latino Health Organization Indianapolis, Elkhart General Hospital (Dame tu Mano), as a way of integrating a mental health promotion program into the health care environment. Partnering with health coalitions or community clinics has allowed the Bienvenido Program, a mental health intervention; to integrate with coalitions who are providing health services. As Indiana looks to integrate health and mental health services in the future it is important to promote partnerships between health centers and mental health centers. The Bienvenido Program intervenes with individuals at health coalitions who are then referred to the mental health center if further emotional support is needed. From February to April 2008 there were 84 Bienvenido participants seen for Bienvenido through the Hispanic/Latino Health Coalition, LEAP of Noble County, and the Learning Generation Initiative. Of these 84, eight were referred to Northeastern Center for mental health treatment services. Now is the time to advance the integration of mental health and physical health care. Effective integration of mental and physical health will enable Indiana to provide appropriate care to its most ethnically diverse and geographically dispersed citizens.

Indiana has been fortunate to see the value in consistently including consumers, children, youth, and families of mental health services on various councils, in meetings, and at the legislative level. It is these individuals that will help agencies identify where the needs are, what types of cultures are present, and how to possibly meet the identified needs. If residents of local communities are engaged in entry-level positions and are developed over

time, agencies should see a more diverse and consistent workforce emerge (Hoge et al., p. 17). Engaging individuals in the area of behavioral health can be challenging due to the stigma surrounding it (Hoge et al., p. 194). One gentleman said “You have to work with *those* people?” after finding out I worked in the behavioral health workforce. This stigma creates an opportunity for our higher education institutes, government, and behavioral healthcare agencies to initiate an anti-stigma campaign while promoting working in the behavioral workforce (Hoge et al., p. 17). The question remains, what are the solutions to the issues listed previously and what does a culturally competent workforce look like in Indiana?

National Context

In the United States cultural diversity has primarily been associated with race and ethnicity; but diversity in recent years has been taking on a broader meaning to include the sociocultural experiences of people with mental illness, social classes, religious and spiritual beliefs, sexual orientations, different genders, ages, and physical abilities (NASW Standards for Cultural Competence in Social Work Practice). All of these areas require a culturally competent and diverse behavioral health workforce.

In largely rural states there have been historical difficulties in recruiting and retaining an effective behavioral health workforce. Additionally, the recent report of the President’s New Freedom Commission on Mental Health described in detail the significant problems facing mental or behavioral health systems across the country, particularly in rural areas. These include critical gaps in accessibility of care due to urban-based models and strategies, and establishing mental health policy without consideration of rural impact (New President’s Freedom Commission, 2003).

National issues for rural behavioral health show a need to address recruitment, retention, and training. Below are national rural workforce behavioral health issues:

- More than 60% of rural Americans live in mental health professional shortage areas.
- More than 90% of all psychologists and psychiatrists, and 80% of MSW’s, work exclusively in metropolitan areas.
- More than 60% of rural Americans get mental health care from their primary care provider.
- Rural Americans enter care later in the course of their disorders, with more advanced symptoms, and require more intensive and expensive interventions.
- Rural Americans travel further to receive mental health services.
- Rural Americans are less likely to recognize mental illnesses, and understand their care options.
- Specialty providers are highly unlikely to be available in rural areas.
- Comprehensive services are not available.
- Few programs train professionals to work in rural places.

A landmark study conducted by the Annapolis Coalition titled, “An Action Plan for Behavioral Health Workforce Development,” states that there is a high degree of concern about the state of the behavioral health workforce

and pessimism about its future (p.1). Furthermore, the report outlines there are significant concerns about the capability of the workforce to provide quality care. “The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience and recovery-oriented practices and are generally reluctant to engage children, youth, adults, and their families” (p.1). The Annapolis report goes on to say there is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population.

The Center for Workforce Studies, National Association of Social Workers, in their special report, “Assuring the Sufficiency of a Frontline Workforce” a national study of licensed social workers, found three major challenges facing the profession (1) replacing the large number ready to retire; (2) recruiting new social workers, especially people of color and men; (3) retaining the current workforce in an increasingly stressful environment. The Workforce Studies report also found that the future sufficiency of a trained frontline labor force in behavioral health is a concern. In addition, social workers in behavioral health organizations report workplace stressors that threaten the quality of care for those with mental health conditions and substance abuse disorders (Center for Workforce Studies, March 2006). The report shows that dramatic changes have occurred in the social services landscape, including demographic shifts, new service models, increased emphasis on accountability, and greater reliance on evidence-based practice.

In states such as California the passage of the Mental Health Services Act has created an opportunity to evaluate and create a working plan for addressing the shortage of behavioral health providers. The Mental Health Services Act Workforce and Education Training Component addresses the shortage of mental health professionals by creating funding mechanisms to support internships, career pathways, residencies, and education for law enforcement and community organizations regarding this shortage (see: www.co.fresno.ca.us Fresno County Mental Health Services Act Workforce and Education 3 year plan, 2009).

In a recent report titled, *Geographic Disparities in Washington State’s Mental Health Workforce*, conducted by the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill, the researchers estimated the need for mental health services in Washington State and the size of the states mental health workforce data specific to Washington State. The purpose of their study was to estimate shortages of mental health professionals at the county and Regional Support Network Levels. The researchers also compared mental health workforce shortages to other states. The report highlights the importance of addressing the shortage of mental health professionals at the state level, but also gives notice to the growing need for a diverse behavioral health workforce at the national level, (Morrissey, et al, 2007).

The Hogg Foundation for Mental Health in Texas recently released a report titled, *The Mental Health Workforce in Texas: A Snapshot of the Issues*. The report highlights the current status of the mental health workforce in Texas. The State of Texas is a mirror to what other states face in terms of shortages among mental health professionals, licensed social workers, licensed psychologists, and licensed psychiatrists. For example, in 2005 there were 1,488 general and child psychiatrists in Texas. The supply ratio per 100,000 population declined from 6.8 in 1990 to 5.6 in 2005. By way of comparison, 2004 supply ratios among the states ranged from 1.11 in Louisiana to 22.5 in Vermont (Hogg Foundation, 2007). The Texas Workforce Commission has projected growth in job availability for selected mental health-related professions between the year 2002-2012 with psychiatrists 20 percent growth rate, mental health and substance abuse social workers at 26.2 percent, mental health counselors at 22.9 percent, and psychiatric technicians at 34 percent. These projections show a clear need for a behavioral health workforce to address the mental health needs of the growing diverse population.

The Oversight Committee for the Mental Health Transformation Initiative, Connecticut recently released an update (2007) stating their approval to fund support for the establishment of the Connecticut Mental Health Workforce Collaborative as a permanent body charged with planning, coordinating, and implementing interventions to strengthen the workforce. Initiatives such as these are addressing the mental health workforce shortage in Connecticut. Interventions such as leveraging existing resources, linking Connecticut's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers, assessing routinely mental health workforce development needs in Connecticut, planning in the form of bi-annual mental health workforce development, and promoting cultural diversity and employment of consumers and family members is at the core of Connecticut's cutting edge mental health workforce plan (Oversight Committee, Update, 2007).

Sustainability Context

As the Division of Mental Health and Addiction looks to address behavioral health workforce issues it should take a close look at the type of projects that are currently being funded at a national level with potential for replication in Indiana. These projects could give leadership to the state of Indiana as related to culture and the workforce and our country's public and private behavioral health sectors. Funding for cultural competency and related fields is currently available through private funding sources. Some foundations provide grants to institutions to develop curriculum, provide training, enhance cultural/ethnic awareness, education to their workforce and service delivery to underrepresented populations. These foundations are interested in supporting the development of cultural competence and sensitivity in the deliverance of services, by preparing professionals to meet the needs of cross-cultural populations. Furthermore, many of these funding sources emphasize dissemination of acquired knowledge as a requirement to receive funding. Past awarded grants from these organizations have ranged from \$250 to \$2.5 million. Some of these foundations provide money to cover general operating support or overhead expenses as well as project specific expenses.

Government grants, which can be searched through www.grants.gov, are also available. Their search process is cumbersome and challenging to be evaluated for this feedback. However, it is important to note that The National Institute of Health (NIH) has published a plan to address health disparities and some relevant grants can be found through the NIH website. Conducting research implies an interest to explore and address needs in a specific area. Public and private sources that provide funding opportunities for to support research should emphasize that cultural competence in the workforce is a critical issue that directly impacts quality of care, and should not be overlooked or minimized. It also reflects a positive momentum towards a greater informed and competent prepared workforce.

A Changing Context

As noted in the introduction, the changing face of America requires the behavioral health workforce to be prepared to interact with all cultural differences, whether this is in ethnicity, sexual orientation, or in socioeconomic status. A lot of people in minority populations are reluctant to speak up. A person's past experiences may have found it to be negative when it was apparent their viewpoint was not valued (Hoge et al., p. 193). The workforce should be aware of the impact a person's culture can have on their treatment (Hoge et al., p. 195). It should also be noted that while preparation is taking place, our workforce is also seeing an aging out of workers. More than half of the trained clinical professionals are over the age of fifty (Hoge et al., p. 7).

Indiana's context description shows positive strides to addressing cultural competency training for behavioral health therapists, but more could be done in areas of linguistic competence. As the report shows the minority population is increasing in Indiana and many are first generation immigrants who have not yet acquired sufficient English language skills. As Hoge states above, minority populations are reluctant to speak up and having poor English skills may deter minorities from seeking mental health services. The use of health promotoras or traditional healers to link minorities to mental health centers could increase access to mental health services. Northeastern Center has developed a mental health facilitator initiative that has increased access to mental health services within the Latino community (Saldaña & Pérez, 2007). The bilingual mental health facilitator is trained in basic mental health topics and then works to create mental health education groups in the Latino community. The facilitator works with Latinos to understand adjustment issues to this country and also refers individuals to mental health centers for emotional support. Also, linkage to faith-based organizations could assist mental health providers with additional ways to address mental health and spiritual needs of persons with mental health and substance use conditions. In addition, placing more emphasis on peer and family mentor supports could augment current service delivery system.

Another example of helping mental health professionals to learn about the key mental health challenges and impact to communities could be to establish a formal relationship with the KEY Consumer Organization to provide trainings to mental health centers on the effects of mental illness. Also, establishing formal relationships with military personnel who understand the emotional and spiritual needs of military veterans will enhance a mental health centers ability to respond to veterans who are attempting to reintegrate into society after having returned from war torn countries.

As stated in the introduction, creating a culturally and linguistically competent and diverse workforce will mean having a workforce that understands the context of the person who seeks mental health services. Furthermore, the workforce will have to grapple with his or her own self-awareness about mental illness, past impressions, personal/life experiences with persons with mental health challenges, learned beliefs, stereotypes, and factual realities that are of the past. Finally, professional practice standards need to be incorporated into the training and methods to demonstrate that the specialized training proposed in this report are working to create a culturally and linguistically competent workforce for Indiana, which ultimately, could correct mental health disparities in Indiana.

According to Rick Ybarra, Hogg Foundation for Mental Health, "Workforce development includes "growing your own...investing in/supporting young case managers with bachelor's degrees to pursue higher education (i.e. Master of Social Work; psychology, etc). Lastly, workforce development includes leadership...to support direct care staff through mentoring, training, and education to advance to leadership roles within the organization. There is a need to cultivate the next group of leaders." A potential way to support this strategy is to provide scholarships with an acceptance agreement by the recipient that they will "payback" the organizations with a length of time commitment to serve the organization post graduation the length of time equivalent to the scholarship. This is the challenge before us. It is our task to develop, solidify and implement and evaluate a plan that will increase the workforce capacity and create the next generation of culturally and linguistically and diverse behavioral health workforce in Indiana. Together, we will create stronger, vibrant, and economically viable mentally healthy communities throughout Indiana. The people of Indiana deserve the best services provided/authorized by the Division of Mental Health and Addiction, nothing less.

Recommendations:

Guided by findings in this profile on cultural competency and the mental health and addiction workforce, the following policy recommendations are suggested as vital bridges between current successes and future aspirations in the development of a culturally and linguistically competent behavioral health workforce in Indiana.

1. Mandate cultural competency training for behavioral health professionals on an annual basis.

As Indiana's DMHA undertakes steps to transform mental health and addiction service provision throughout the state to focus on participation of children, youth, families and consumers in the development, delivery and evaluation of mental health and addiction services, DMHA recognizes that emphasis on culturally appropriate and competent service provision is paramount for success in this transformation. Even more compelling, studies like that of Whaley and Davis illustrate the complementary nature of cultural competence and evidence-based practice in mental health services for effective intervention, especially for ethnic/racial minority populations. (Whaley, A. & Davis, K., 2007) Furthermore, the Commission on Disproportionality in Youth Services recommended requiring mandatory ongoing cultural competency training for mental health care providers and substance abuse providers among other service providers working with minority youth populations. In addition, the commission also recommended that there should be a requirement to monitor service delivery practices and outcomes to ensure that such training is implemented into policies and practices. The foregoing recommendation was not only overarching across the four systems under consideration, but specific to mental health as well. A complementary recommendation from the commission was that evidence-based programs using strength-based approaches should be used as models to change the culture of agencies providing services. As demonstrated by recommendations guided by the findings from the commission and previous studies, mandating cultural competency training is imperative for mental health providers to effectively serve the diversifying population today and in the future.

2. Adopt policies that promote and ensure workforce diversity.

The Surgeon's general report of 2001, studies, and the commission on disproportionality have established the notable lack of racial and cultural diversity among the mental health disciplines – nationally and locally depending with their scope. It has been estimated that over 90% in most mental health disciplines are non-Hispanic whites (Duffy et al, 2004). The commission noted the lack of diversity may affect access to mental health care among the unrepresented populations and contribute to cultural misunderstandings that may lead to undiagnosed and misdiagnosed mental health cases respectively (Indiana Disproportionality Commission, 2008). The commission further recommended the need to develop a strategic plan to recruit and retain diverse professionals in the four systems, including mental health and include deliberate efforts to increase awareness and interest in the professional areas within all education levels. (Indiana Disproportionality Commission, 2008) Therefore, in responding to the demands of the changing demographic in Indiana and to fully achieve the transformation in mental health service focusing on clients and families, it is essential to develop and implement policies to promote and ensure workforce diversity.

3. Develop and continuously update a mental health and addiction workforce database to record and keep track of diversity.

It will be beneficial to develop and continuously update a mental health and addiction workforce database. Such a database would help in referrals identifying providers that may offer specific cultural knowledge, skills, and abilities; also the database may be used to promote distribution of culturally competent providers by encouraging them to potentially serve in shortage areas that may need their expertise. Similarly, the commission on disproportionality in youth services recommended creation of a listing of service providers and organizations that

identifies specific cultural areas of expertise to assist in referral of minorities with mental health and addiction needs. (Indiana Disproportionality Commission, 2008).

4. Require each treatment center that accepts public funding to create a Cultural Competency Advisory Council with the purpose of creating a cultural competency plan that addresses trainings, recruitment, retention and cultural resources.

As community mental health centers continue to receive more diverse consumers it is imperative for staff to be prepared to effectively engage consumers and their families. The cultural competence advisory council would be responsible for creating a cultural competency strategic plan at the community mental health center. Working proactively to ensure that staff is adequately trained and policies are developed to ensure training on a yearly basis could increase the overall experience of the diverse consumer at the community mental health center. The cultural competence advisory council could also explore the feasibility and merits of conducting an organization cultural competence assessment. The cultural competence advisory council would recruit consumers, family members and key community stakeholders to assist in implementing the cultural self-assessment. This advisory council would address ethnicity, sexual orientation, religious, and socioeconomic sectors. This council would be the “go-to” people for overseeing all the recommendations above. The responsibility for implementing these recommendations could or could not fall to this council, but they would be the entity that would help define those cultures, resources, and trainings. Indiana already has various committees that focus on individual cultures. The actual creation of this council would be to utilize individuals from those committees along with leaders in the behavioral health workforce.

5. Create online resources that provide information on different cultures with respect to mental health and addiction.

Workers do not always have time or access to trainings and online resources that could help meet their time constraints. For example, a worker is dealing with a Latino female that is in need of housing but is also showing signs of depression and PTSD due to past family related trauma. The worker could then access the online resources. The resources could address both housing and articles on the importance of family in the Latino culture. The worker will then feel empowered and equipped to treat the person seeking services effectively.

6. Require mental health and addiction providers to have individuals qualified to interpret mental health and addiction medical information to limited or non-English speaking and hearing impaired consumers.

Data show that minority populations underutilize mental health services due to limited English speaking skills. For those who have limited English, having an interpreter to assist in venting their life situations will create a supportive environment. For members of the community who are mentally ill consumers and also have a hearing impairment, accessing services may prove to be more challenging. Establishing formal relationships with groups such as Deaf Link or others will demonstrate the mental health centers willingness to address the needs of all people. Barriers are broken for the hearing impaired and the limited English speaker when they observe mental health providers making an attempt to meet their needs.

7. Continue to participate in the national advisory council on cultural competency.

Findings in this report show states across the U.S. are addressing behavioral health workforce issues and their efforts prove to be beneficial in terms of structure, recruitment, retention, and planning. Indiana is currently participating in the Cultural Linguistic Committee. The committee is through Georgetown University’s National Center for Cultural Competence. Their focus is on “translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy”

(National Center for Cultural Competence). The findings of this report show that such an involvement could help Indiana even more to improve the level of cultural competency in the behavioral workforce.

References

- Center for Workstudies. (2006). Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Washington, D.C. National Association of Social Workers & Center for Health Workforce Studies, School of Public Health, State University of New York, University at Albany.
- Connecticut State Mental Health Incentive Grant. (2007). Oversight Committee Update, mental health workforce collaborative. (see: <http://www.ct.gov/dmhas/lib/dmhas/transformationgrant/updatejune007.pdf>).
- Division of Mental Health and Addiction (DMHA) Survey, (2006). Unpublished Demographic Survey Database.
- Duffy, F. F., West, J. C., Wilk, J., Narrow, W. E., Hales, D., Thompson, J., et al. (2004). Mental health practitioners and trainees. In R. W. Mandersheid and M. J. Henderson (Eds.), *Mental health, United States, 2002* (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Fresno County Mental Health Services Act Workforce and Education Three year plan, 2009. (see: www.co.fresno.ca.us).
- Gordon, M.M. (1978). Human nature, class, and ethnicity. New York: Oxford University Press.
- Hoge, M.A. (2007). An Action Plan for Behavioral Health Workforce Development. A Framework for Discussion. 2007. Annapolis Coalition, Maryland. <http://208.106.217.45/pages/images/WorkforceActionPlan.pdf>
- Indiana Disproportionality Commission. (2008) A report of The Commission on Disproportionality in Youth Services: Findings and Recommendations.
- Kramer, J. M. (2009). Letter to Northeastern Center regarding the Bienvenido Program. Available at gperez@nec.org.
- Lum, D. (2007). Culturally Competent Practice: A Framework for Understanding Diverse Groups and Justice Issues. Thomson: Brooks Cole.
- Mental Health Research Findings: Program Brief. Agency for Health Research and Quality. DHHS. Pub. No. 09-P011. September 2009.
- Morrissey, J.P. (2007). Geographic Disparities in Washington State's Mental Health Workforce. Technical Appendix. Cecil G. Sheps Center for Health Services Research, University of North Carolina.
- National Center for Cultural Competence (Creation date not specified) *About Us*. Retrieved on October 26, 2009 from <http://www11.georgetown.edu/research/gucchd/nccc/about.html>
- President's New Freedom Commission on Mental Health, (2003) Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD. <http://www.mentalhealthcommission.gov/>

Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. London: Collier Macmillan.

Saldaña, D., & Pérez, G. (2007). Program Evaluation Report, Bienvenido Program: Good Mental Health for the Latino immigrant (www.nec.org).

Standards for Cultural Competence in Social Work Practice. 2001. National Association of Social Workers. Washington, D.C. www.socialworkers.org

States Indiana Profile: *Population*. Retrieved September 17, 2009 from <http://www.stats.indiana.edu/sip/> (Updated: September 15, 2009 at 12:16)

Stats Indiana: *Population projections*. Retrieved September 17, 2009 from <http://www.stats.indiana.edu/topic/projections.asp>

The Mental Health Workforce in Texas: A Snapshot of the Issues. 2007. The Hogg Foundation for Mental Health. Austin, Texas. (see <http://www.hogg.utexas.edu/PDF/TxMHworkforce.pdf>).

U.S. Census Bureau, 2004. <http://www.census.gov/>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). (2007) *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*. <http://www.hhs.gov/>

Whaley, A. & Davis, K., (2007). Cultural competence and evidence-based practice in mental health services. *American Psychologist*, 62(6), 563-574.

Chapter 4. Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines Subcommittee Report

Mission Statement:

The goals of the Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines subcommittee were to assess current training curricula and teaching methods in core disciplines; and engage training programs in recommending ways to improve the “readiness” for students moving into the current workforce. The resulting recommendations are presented in this report to the Workforce Development Task Force of the Transformation Work Group.

Subcommittee Membership	
Dennis Ailes	<i>Bureau Chief of Addiction Treatment Services, Division of Mental Health and Addiction</i>
Cathy Alsman	<i>Associate Professor, Program Chair Human Services Program Ivy Tech Community College of Indiana</i>
Rhonda Ames	<i>Executive Director, Key Consumer Organization</i>
Dean Babcock	<i>LCSW, Associate Vice President, Midtown Community Mental Health Center</i>
Dr. Joanna Chambers	<i>M.D., Psychiatrist, Indiana University Medical Center</i>
Eric Comstock	<i>M.A., LMFT, Program Chair / Assistant Professor - Human Services Program, Ivy Tech Community College-Central Indiana</i>
Helene Cross	<i>President/Chief Executive Officer, Fairbanks, Experts in Addictions, Focused on Recovery, Subcommittee Chair</i>
Ruth Gussman	<i>Ph.D, Director, Indiana Prevention Resource Center and Assistant Professor, Indiana University's Department of Applied Health Science, School of Health, Physical Education and Recreation.</i>
Kathy Lay	<i>Ph.D. Associate Professor, Indiana University School of Social Work</i>
Robert M. Levy	<i>Ph.D., Professor Emeritus of Psychology, Indiana State University Director of Research and Evaluation Criterion Health, Inc.</i>
Kathleen L. O'Connell	<i>PhD, RN, Associate Vice Chancellor for Faculty Affairs Director, Behavioral Health & Family Studies Institute, Professor of Nursing</i>
Don Osborne	<i>MS, MA, MAC, Director of Graduate Addictions Counseling, Director of the Addiction Studies Center, Indiana Wesleyan University</i>
Susan Pieples	<i>President, Autism Society of America, Indiana Chapter</i>
Rev. Rebecca L. Smith	<i>MDiv/CE, CPP, Pastor/Consultant, Community Consultant, Indiana Criminal Justice Institute</i>
Diana Williams	<i>Deputy Director, Mental Health Policy and Planning, Division of Mental Health and Addiction</i>

Vision for Workforce Development:

Indiana promotes an overall health and wellness model rather than a disease-oriented treatment model in its approach to mental health and addiction recovery, and primary care, on a continuum from promotion and prevention through recovery.

A major challenge for workforce development is to establish the context that meets current and anticipates future needs. The academic, i.e., undergraduate and graduate education and training, as well as the continuing education and training for the health care workforce reflects the underlying health care model. That current predominant model is disease-oriented treatment, with its respective silos for mental health, substance abuse and addiction, and primary care. An integrated health and wellness model will focus attention on mental health promotion, mental illness and substance use prevention, intervention, treatment, and recovery consistent with the World Health Organization's definition of health as "A state of complete physical, mental and social well-being, and not merely the absence of disease." Advances in the training and education for programs specifically focusing on mental health and substance abuse and addiction are not enough. The adoption throughout the entire health and human services education, training, and services system of a health and wellness model and its underlying values would, first, establish the conceptual framework for an integrated health system and, second, drive the curricular systems for integrated care.

Survey of Academic Institutions Results:

To assess current training curricula and teaching methods in core disciplines, the subcommittee surveyed various academic institutions around Indiana and in other states to obtain a sampling of course syllabi and outlines as well as the considerable collective experience of the members. As a result of this review, these observations are offered for consideration:

1. Academic institutions currently offer substantive curricula and teaching methods reasonably consistent within core disciplines in most areas of mental health.
2. Academic institutions currently offer inconsistent and insufficient curricula in core disciplines in the areas of mental health promotion, substance use prevention, and mental health and addiction recovery.
3. Academic institutions currently offer inconsistent curricula and teaching methods across core disciplines in health, mental health, and addiction recovery.
4. Academic institutions currently offer inconsistent and insufficient curricula and teaching methods in core disciplines in the areas of integration of physical health, mental health promotion, substance use prevention, and mental health and addiction recovery.
5. The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), having made similar observations in recent years, is working toward identifying and solving many of these same workforce development deficiencies.
6. Subcommittee findings from assessing current training curricula and teaching methods in core disciplines generally agree with SAMHSA findings to date.

Students “Readiness” Recommendations:

The Subcommittee began an earnest yet meager effort to engage training programs in recommending ways to improve the “readiness” for students moving into the current workforce. Representatives from several Indiana academic institutions and core disciplines consensually offer the following recommendations:

1. DMHA is encouraged to continue collaborating with academic institutions and other interested parties in developing consistent evidence-based curricula and teaching methods for the growing behavioral health workforce. We encourage an approach that promotes an overall health and wellness model for mental health and addiction recovery and primary care, on a continuum from promotion and prevention through recovery. The support and development of faculty and educators is a critical area of need if workforce development is to advance.
2. DMHA is advised to develop partnerships with academic institutions, core disciplines, and other individuals and organizations, including persons in recovery, to advance health, wellness, and evidence-based practices from resource identification through translational research.
3. DMHA is encouraged to prioritize workforce development from continuing education and training of current and future professionals, from psychiatrists to recovery specialists including health, wellness, prevention, evidence-based practices ranging from infant and toddler mental health to mental health of adults.
4. DMHA is encouraged to become a leader of self-directed computer and Web based learning in which all of the health and human service workforce can continue to seek the best education and information regarding mental health and addiction information and best practice. This resource should be implemented in order to achieve positive outcomes and implement effective interventions based on the most current research evidence.
5. DMHA is encouraged to look at its overall mission and recommend that the mission be wellness focused, rather than disease and diagnosis focused.
6. DMHA is encouraged to develop partnerships locally and federally to secure funds to create more translational research.
7. Through the Annapolis Coalition, the Substance Abuse Mental Health Services Administration (SAMHSA) has endorsed core competencies for addiction counseling and urges the development of core competencies for mental health practice. Human Service Professionals, including law enforcement should be trained in competencies in mental health and addiction so that screening, brief intervention, referral and treatment can occur in all health and human service venues.

In conclusion, the Workforce Development Task Force invested a lot of time, effort, and expertise in thoroughly reviewing the Behavioral Health Workforce issues within our state. We submit this report to the Mental Health and Addiction Transformation Work Group in accordance with House Bill 1210 and look forward to continuing to partner and assist where necessary in order to advance the **recommendations** found within this report.

Appendix A. Physician Workforce in Behavioral Health in Indiana: Data from the DDPAT

In 2007, Indiana DMHA commissioned the design and implementation of a physician workforce study instrument that would characterize the physician workforce providing clinical care at DMHA-supported centers. Several design features of the study instrument (the Dual Diagnosis Physician-infrastructure Assessment Tool (DDPAT)) were aimed to provide information about institutional involvement and individual physician involvement and expertise in the care of patients with dual diagnosis disorders, since co-occurring addictions and mental illness characterizes the mainstream of cases treated by these centers. The goal of this study was to 1) develop a novel workforce instrument that may be useful to Indiana and other states in gauging the professional crisis in behavioral health care and dual diagnosis treatment; and 2) provide 'actionable intelligence' on the behavioral health physician workforce in Indiana to relevant stakeholders in behavioral health care in Indiana. The results of this study, as presented here, have been accepted for publication in *Psychiatric Services*, the leading and most widely circulated journal on Behavioral Health Care delivery in the United States (Chambers, RA, Connor, MC, Boggs, C, Parker, G (in press) "The Dual Diagnosis Physician-infrastructure Assessment Tool (DDPAT: Examining State-Funded Facilities and Physician Workforce Attributes) *Psychiatric Services*).

Method:

All major clinical centers receiving significant funding from Indiana DMHA were assessed in the survey (30 Community Mental Health centers (CMHCs); 13 Addiction Treatment Centers (ATCs); 6 State hospitals) from February to October of 2007. The study instrument was deployed in two phases (each by phone contacts and web-based surveys): Phase 1 was a 10-part questionnaire directed to the administrative leadership of the centers (e.g. to characterize services provided by the centers); Phase 2 was a 10-part questionnaire directed to each of the individual physicians employed by the centers. The content of these phases addressed the following:

Phase I: Treatment Centers

1. Name of organization
2. Number of treatment sites
3. Type of treatment provided (inpatient and/or outpatient)
4. Primary treatment focus (mental illness, addictions or both (separately or integrated))
5. Specific addictions services (inpatient detoxification and/or outpatient opiate treatment)
6. Patient population (primarily children, adults, or both)
7. Number of unfilled physician positions (FTEs)
8. Number of individual physicians on staff

9. Names and contact information of physicians
10. Number of non-physician prescribers on staff

Phase II: Individual Physicians

1. Physician identifier code
2. Age
3. Clinical specialty by residency training
4. Primary clinical role (psychiatric care, general addiction, treatment of opiate addictions, combination of psychiatric illness and addictions, medical care)
5. Number of hours per week at this center
6. Site of residency training (in-state, out-of-state, other)
7. ABPN certification in psychiatry
8. ABPN certification in addiction psychiatry
9. ABPN certification in child psychiatry
10. ASAM certification

Results:

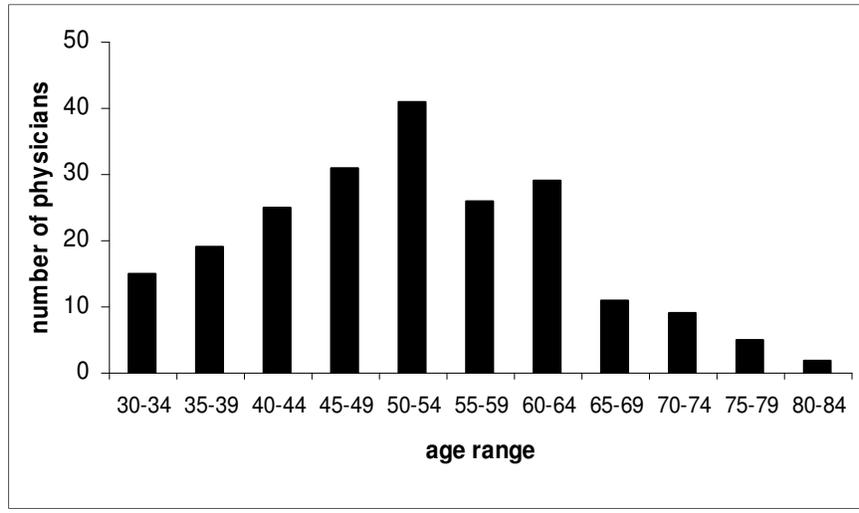
Participation:

All 49 (100%) treatment centers responded to Phase I, reporting a total of 286 physicians on staff, of whom 215 (75%) completed Phase II. Physician response rates ranged from >93% at state hospitals and addiction treatment centers to 67% at CMHCs. Four of 6 hospitals, 11 of 13 addiction centers and 8 of 30 CMHCs had 100% physician response rates.

Overall physician workforce shortages:

As a fraction of the total medical staff (of whom only half were full-time), the need for new full-time physicians in 2007 was 30%, 12% and 32% in state hospitals, CMHCs, and ATC's, respectively. These and related findings suggest the presence of a longstanding and chronically worsening inadequacy of production of new psychiatrists in Indiana. First, the total number of physician FTEs needed (55.9) state wide is more than nine times larger than the annual class size (6) of Indiana's only psychiatry training program, at the Indiana University School of Medicine. Second, only 27% of all surveyed physicians trained in psychiatry in Indiana, even though this school is the second largest medical school in the U.S. by medical student class size. Third, progressive decreases in the numbers of employed physicians in age groups below 50 years suggests chronically extinguishing production rates of new psychiatrists and/or rates of entry into public sector psychiatry (**Figure 2**).

Figure 2 Age diagram of physicians employed at Indiana CMHC's, state hospitals, and addiction treatment centers. Approximately 90% of physicians were psychiatrists; other primary care doctors (internal medicine, family medicine, surgery) represented <10% of this workforce. Physicians aged 50-54 outnumbered those younger than 35 by nearly three-fold. About 4 in 10 (38%) were within a decade or beyond a retirement age of 65, but only 16% were aged 30-39. CMHCs employed 77% of this workforce, which was also the youngest cohort with a mean age of 51 years. Hospitals employed 7% of the workforce with the oldest cohort and mean age of 59.



Institutional Shortfalls in Dual Diagnosis/Addictions treatment:

Dual diagnosis presentations are mainstream in patient populations seeking treatment for either mental illnesses or addictions. While the majority of CMHCs (97%) reported providing treatment for both addictions and mental illness (either as segregated or integrated treatments), only a minority of hospitals (33%) and ATCs (33%) reported this dual diagnosis capability. Then, although CMHC's reported high rates of dual diagnosis capability, only about half of these centers (53%) actually provide inpatient detoxification service options; only 13% provide outpatient opiate maintenance therapy service options; and only one of 30 centers state wide provided both of these types of services. Since both of these treatment options (e.g. inpatient detox and outpatient opiate maintenance) are considered standard of care evidence-based treatment modalities for addictions, these findings suggests that center's definitions of dual diagnosis treatment capability does not often actually encompass provision of standard of care treatments for addictions. With respect to these addiction treatment options, ATC's actually provided fewer options overall compared to CMHCs. Moreover, physician involvement was sparse at most ATC's and non-existent at 4 of 13 centers surveyed, indicating that ATCs are least well equipped (and often not staffed) to provide standard of care/evidence based pharmacological and psychotherapeutic treatment services for addictions. As suggested in the physician workforce characteristics presented below, formal expertise in psychiatric addictionology was rare in the physician workforce, and when present, was not often being utilized in the care of dual diagnosis patients.

Shortages in physician expertise and involvement in Dual Diagnosis/Addictions treatment:

Physician staffing profiles (training backgrounds/certifications/specialties) according to treatment center type are shown in **Table 2**. Formal training in addictions indicated by certifications in addiction psychiatry (ABPN) or addiction medicine (ASAM) characterized only 3% vs. 5% of the entire physician workforce respectively. Then, of the three-quarters of all physicians surveyed who worked at CMHCs, only 30% described their primary clinical role as treating both mental illnesses and addictions, even though 97% of CMHCs reported dual diagnosis

capability. Only a minority of addiction certified physicians (either ABPN or ASAM) identified their primary clinical role as treatment of both mental illness and addictions. The majority of ABPN-certified addiction psychiatrists (57%) were employed at the state hospitals, while the addiction treatment centers hosted the highest overall percentage of addictions-certified physicians (21%), even though only a minority of these centers reported dual diagnosis capability. Taken together, these findings suggest a disconnect between how centers report their dual diagnosis capability and levels of physician expertise and involvement in dual diagnosis care.

Section Summary

The DDPAT uncovered evidence for chronically worsening shortages of psychiatric physicians in behavioral health care in Indiana. Only a minority proportion of the physician workforce that works in Indiana was also trained in Indiana, suggesting the under-production of psychiatric physicians has been long-standing. Moreover, since nearly 40% of the workforce was within a decade of retirement, and given the low production of new psychiatrists ongoing in Indiana, these shortages are expected to get worse. With respect to treatment of dual diagnosis disorders, DMHA-supported clinical centers broadly lack sufficient institutional treatment programming and suffer from profound shortages of physician-based expertise in providing evidence-based, standard of care treatments for dual diagnosis patients, inclusive of both pharmacological and psychotherapeutic modalities.

	Hospitals (N = 35)		CMHCs (N = 166)		Addiction Centers (N = 14)		All (N = 215)	
Mean age (years)	58.6 ±12.8		50.5±10.6		50.6 ±14.3		51.8±11.6	
	N	%	N	%	N	%	N	%
CLINICAL SPECIALTY								
General Specialty	22	63	124	75	6	43	152	71
Child Psychiatry	4	11	37	22	1	7	42	20
Internal Medicine	3	9	1	1	0	--	4	2
Pediatrics	0	--	0	--	0	--	0	--
Family Medicine	3	9	2	1	6	43	11	5
Surgery	1	3	0	--	1	7	2	1
Neurology	0	--	0	--	0	--	0	--
Emergency Medicine	0	--	0	--	0	--	0	--
Other	2	6	2	1	0	--	4	2
TREATMENT ROLE								
Mental Illness	19	54	112	68*	3	21	134	63
Addictions	1	3	1	1	3	21	5	2
Opiate Addictions	0	--	1	1	0	--	1	<1
Mental Illness & Addictions	9	26	50	30	3	21	62	29
Medical Care	6	17	1	1	5	36	12	6
HOURS/WEEK								
Full Time (40+)	26	74	81	49	4	29	111	52
30-40	2	6	36	22	1	7	39	18
20-39	3	9	30	18	0	--	33	15
6-19	3	9	15	9	3	21	21	10
<6	1	3	4	2	6	43	11	5
PSYCHIATRIC RESIDENCY								
Indiana	7	20	47	28	3	21	57	27
Out of State	21	60	116	70	4	29	141	66
Non-Psychiatrist	7	20	3	2	7	50	17	8
ABPN CERTIFICATION								
General Psychiatry	16	46	118	72	4	29	138	64
Child Psychiatry	3	9	17	10	0	--	20	9
Addiction Psychiatry	4	11	3	2	0	--	7**	3
ASAM CERTIFICATION								
	0	--	8	5	3	21	11	5

*Missing case excluded; one CMHC physician did not respond to treatment role question.

**4 of 7 with ABPN certification in addiction psychiatry were grandfathered in.

Appendix B. Spanning Behavioral Health Professionals: The Recruitment and Retention Survey

Building on the investigative approach used in the DDPAT study, the Recruitment and Retention workgroup developed and implemented a new survey designed to assess workforce hiring and turnover conditions inclusive of the broad scope of professionals making up the entire behavioral health workforce. Much of the preliminary work in this effort was dedicated to determining a manageable list of discrete professional types. Behavioral health professionals can be titled and characterized by a wide variety of descriptors, including degree type, educational attainment, licensure, specialty or subspecialty certifications, role descriptions, and actual clinical/supervisory duties. In practice, we found that there is considerable heterogeneity of terminologies used to describe professional positions, and variance in how each of these descriptors relate to one another or actual clinical responsibilities. With these considerations in mind, the committee settled on the following list of 13 professionals, acknowledging that it is an imperfect list, and that some of the positions may be differentially interpreted by the specific centers:

- Psychiatrist (M.D. D.O.)
- Psychologist (PHD, Psy D (HSPP))
- Nurse (RN, LPN)
- APRN (Advanced Practice Nurse Practitioner or equivalent Rx capable)
- PA (Physician Assistant)
- Case Manager (Associates or Bachelors Level)
- Social worker (Masters Level / LCSW)
- Mental Health Clinician (Associates or Bachelors Level)
- Mental Health Clinician (Masters Level (LMFT, LMHC))
- Substance Abuse Counselor (Associates or Bachelors Level)
- Substance Abuse Counselor (Masters Level)
- Behavioral health technician/assistant (High school diploma or G.E.D)
- Pharmacist

With respect to these professional types, the Recruitment and Retention Survey was designed a 15 item questionnaire with mixed quantifiable and open-ended questions that address the following issues:

- 1) Types of Clinical Professionals in greatest need

- 2) Types of Diversity Professionals Needed
- 3) Types of Psychiatric Sub-specialists in greatest need
- 4) Difficulties in Recruitment
- 5) Current Methods of Recruitment
- 6) Potential Solutions to Recruitment Problems
- 7) Retention Difficulties
- 8) Future Challenges

Data collection for the survey was carried out by the membership of the recruitment and retention subcommittee in September and October of 2009. All major DMHA-supported clinical sites were assessed (27 CMHCs, 6 State hospitals, and 12 ATCs) for the 2009 survey, in addition to 5 'other' sites including community health centers that are not robustly funded by DMHA but which may have behavioral health missions. Each member of the investigative subcommittee was assigned 3 to 5 clinical sites to survey, typically conducted in face-to-face or telephone interviews with the administrative leadership and human resources staff of each center. Only selected results from the 5 'other' sites are presented here as they were not generally staffed by behavioral health professionals.

Types of clinical professionals in greatest need

Method

From the provided list of the 13 professional types, we asked centers to choose 3 that they most greatly need for achieving its clinical mission, and rank them as 1) highest need; 2) second highest need; and 3) third highest need. These choices were to be made independent from considerations about recruitment and retention difficulties.

Results

CMHCs (N=27):

Psychiatrists were most frequently selected as the highest profession in need (14/27). APRNs (nurses capable of prescribing psychiatric medications) were selected most frequently as the second highest profession in need (12/27), and social workers (Masters level LCSW) were selected most frequently as the third highest need (10/27).

State Hospitals (N=6)

Nurses (RN/LPNs) were most frequently selected as highest need (3/6). Behavioral health technicians/HS diplomas, were most frequently selected as the second highest need (2/6), while psychiatrists and pharmacists tied for being most frequently selected as third highest need (2/6 each).

ATCs (N=12)

Substance abuse counselors (Masters level) were ranked as both the greatest need (6/12), and second greatest need (4/12). Case managers (Bachelors or Associates) were selected most frequently as the third greatest need.

Other (e.g. community health centers) (N=5):

Social workers (Masters level / LCSWs) (3/5), psychiatrists (2/5) and Case managers (Bachelors or Associates), were most frequently ranked as the first, second, and third highest need professions respectively.

All Centers (N=50):

Psychiatrists were most frequently selected as the highest need (18/50), APRNs the second highest need (12/50) with case managers (Bachelors/Associates) and Social workers (Masters (LCSWs)) tied for the third highest need.

Summary/Interpretation

Although psychiatrists were most broadly needed, the types of professionals needed varied considerably by center type. Prescribing professions (Psychiatrists/APRNs) were in greatest need at CMHCs, while hospitals needed more personnel for daily management of patients. ATCs, many of which have no or very little physician staffing, likely do not often see themselves as providing treatment following a medical model, and so are in need of specialists providing purely group or individual psychotherapeutic modalities of care.

Types of Diversity Professionals Needed

Method

Centers were asked to choose from, or write in needs in terms of professionals who represented specific diversity groups, or who are multilingual.

Results and Summary/Interpretation

Across CMHCs, Hospitals, ATCs and community health centers, there was broad agreement for a high unmet need for greater numbers of professionals from the African American and Latino Communities. Need for other professional diversity group representation was also cited, or suggested such as for Asian, hearing impaired, Burmese, Somali, Chinese, Vietnamese, Amish, Women and Caucasian subgroups. However, overall ratings of 'high' or 'moderate' need for either African American or Latino professional representation was reported 10 to 20 fold more frequently than for these other diversity groupings. Notably, there were quite region specific needs for specific groups (e.g. Burmese representation was needed in one community that uniquely had a high Burmese immigrant population). Other notable features of this data included 1) an unmet need for more female clinicians in the addictions treatment area (reported by ATCs); and 2) more Caucasian clinicians needed as reported by public health centers. The significance of the latter reporting is unclear. It could be interpreted to mean that foreign (i.e. non-white/foreign national) professionals have traditionally been rather exclusively recruited to underserved rural areas. The high unmet need for African American and Latino professions was a problem across all professional disciplines (regardless of educational level), although the absolute highest rates of need was reported for Case Managers (Associates or Bachelors) and Social Workers (Master's level, LCSW).

The need for multilingual professionals across all treatment centers was by far most frequently reported for Spanish speaking professionals, garnering a 'high' need from 20 of 50 centers surveyed and a 'moderate' need from 20 other centers. Burmese and American Sign Language fluency were the only other two languages where a 'high' need was expressed (<3 centers reporting for each). Low frequencies of 'moderate' need were also reported for fluency in Chinese, Vietnamese, German, Somali, Croatian, and 'Eastern European' (<4 centers reporting for each).

Types of Psychiatric Sub-Specialists in Greatest Need

Method

There are currently 5 forms of board certified sub-specialties in psychiatry requiring fellowship training after residency (Addictions, Child, Geriatric, Forensic, Clinical/Liaison (CL, e.g. psychiatrists who consult closely with primary care doctors). Centers were asked if each of these types of specialists were in 'high', 'moderate' or 'low' need.

Results

CMHCs (N=27):

Child psychiatrists were most frequently selected as the highest need (16/27), addiction psychiatrists as moderate need (14/27) and both forensic and clinical/liaison (CL) psychiatrists as lowest need (14/27) each.

State hospitals (N=6):

Geriatric and forensic psychiatrists were in greatest need (3/6 each), with CL psychiatrists (3/6) in moderate need, and addictions and child psychiatrists in lowest need (3/6 each).

ATCs (N=12):

Addiction psychiatrists were selected most frequently as in highest need (4/12) and moderate need (3/12) with forensic psychiatrists in lowest need (10/12).

Other (e.g. community health centers) (N=5):

Addiction psychiatrists were ranked most frequently both as highest in need (3/5), and moderately in need (1/5). Child, geriatric, forensic and CL psychiatrists were ranked equally as lowest in need.

All Centers (N=50):

Child psychiatrists were most frequently ranked as in greatest need (20/50), addiction psychiatrists in moderate need (20/50) and CL psychiatrists in lowest need (25/50).

Summary/Interpretation

Overall, need for child and addictions psychiatrists were in greatest need, especially for the outpatient missions in behavioral health. Hospitals were uniquely in need of geriatric and forensically-trained physicians, likely owing to the nature of their long-term stay hospital populations. The relatively low need for addiction psychiatrists in hospitals was likely not representative of the degree to which these populations suffer with co-occurring addictions,

but may reflect the fact that captive patient populations have relatively little opportunity to use substances and so addictions is not viewed as a major/acute clinical problem to be addressed in these settings. Notably, the IU Department of Psychiatry, with the exception of child psychiatry, is not equipped with sufficient infrastructure in terms of faculty depth or training stipends to produce these specialists in significant numbers. Of about 5-8 total resident/fellows graduating per year, 2-4 are child psychiatrists or triple boarded in child/adult psychiatry/pediatrics, and 0-1 are addictions or geriatric psychiatrists (e.g. often none/year). There is no viable CL training program at the IU School of Medicine.

Difficulties in Recruitment

Method

Recruitment difficulty was evaluated as an independent issue from either general need for a given type of professional, or difficulty in retention. Centers were asked to rank each of the 13 professional types as 1 (most difficult); 2 (moderately difficult); or 3 (easiest) to recruit. For each professional type that centers ranked as a 1 (most difficult), they were asked to choose up to three of 10 pre-provided reasons for this difficulty, with respect to this professional type. Finally, centers were asked to elaborate with open ended responses on reasons for recruitment difficulties.

Results

CMHCs (N=27):

The top five most difficult to recruit positions:

PROFESSIONAL TYPE	MEAN SCORE
1. Psychiatrists	(1.41)
2. Social workers, Masters (LCSW)	(1.59)
3. APRNs	(1.84)
4. Substance Abuse Counselors, Masters	(1.92)
5. Nurses	(1.92)

Top 3 reasons for difficulty in recruiting:

Psychiatrists

- 1) too small a candidate pool for this type of professional (18 responses)
- 2) not interested in moving to our rural area (13 responses)
- 3) we can't offer competitive salary (8 responses)

Social Workers, Masters (LCSW)

- 1) too small a candidate pool for this type of professional (9 responses)
- 2) we can't offer competitive salary (5 responses)

- 3) tied: not interested in moving to our rural area/ competition with another employer near us (4 responses each)

APRNs

- 1) too small a candidate pool for this type of professional (12 responses)
- 2) not interested in moving to our rural area (6 responses)
- 3) we can't offer competitive salary (4 responses)

State hospitals (N=6)

Top five most difficult to recruit positions:

PROFESSIONAL TYPE	MEAN SCORE
1. psychiatrists	(1.17)
2. nurses (RN/LPN)	(1.5)
3. pharmacists	(1.5)
4. psychologists	(1.67)
5. social workers, Masters (LCSW)	(1.83)

Top 3 reasons for difficulty in recruiting:

Psychiatrists

- 1) we can't offer enough job perks to be a competitive employer (4 responses)
- 2) too small a candidate pool for this type of professional (3 responses)
- 3) we can't offer competitive salary (3 responses).

Nurses

- 1) we can't offer enough job perks to be a competitive employer (3 responses)
- 2) competition with another employer near us (3 responses each)
- 3) we can't offer competitive salary (2 responses)

Pharmacists

- 1) we can't offer competitive salary (5 responses)
- 2) competition with another employer near us (3 responses each)
- 3) tied: too small a candidate pool/not interested in moving to our rural area (2 responses)

ATCs (N=12):

Top five most difficult to recruit positions:

PROFESSIONAL TYPE	MEAN SCORE
1. Substance abuse counselors, Masters	(1.83)
2. Social workers, Masters (LCSW)	(2.18)
3. Mental Health Clinician, Masters	(2.5)
4. Substance Abuse Counselors, Bachelors/Associates	(2.67)
5. Psychologists	(2.7)

The top 3 reasons for difficulty in recruiting:

Substance abuse counselors, masters

- 1) too small a candidate pool for this type of professional (4 responses)
- 2) we can't offer competitive salary (3 responses)
- 3) educational requirements and experience requirements are often out of sync (2 responses)

Social workers, Masters (LCSW)

- 1) too small a candidate pool (2 responses)
- 2) four-way tie: can't offer enough job perks/can't offer competitive salary/educational requirements and experience requirements are often out of sync/ lack of our own recruitment capability (1 response each).

Mental Health Clinician, masters

- 1) all tied: too small a candidate pool/can't offer competitive salary/educational/experience requirements out of sync (1 response each)

Open ended responses:

The following categories were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

- Problems with sites of clinical mission
- Problems with culture of clinical mission/professional support
- Problems with professional pools and competition
- Problems with hiring process

Summary/Interpretations

For CMHCs and State Hospitals, psychiatrists were rated as the most difficult of professionals to recruit. Non-prescribing professionals were rated as most difficult to recruit at ATC's as they may be less likely to see medical treatment for addictions as part of their mission and/or are not able to afford physician support, and so do not invest effort in recruiting these professionals. Across all treatment centers and professions, 'too small a candidate

pool' was selected most frequently as the leading cause of recruitment difficulty. This cause was the leading cause with respect to the following 6 professional types: (psychiatrists, psychologists, APRNs', social workers (masters), substance abuse counselors (BS/Associates), substance abuse (Masters). The second and third leading causes of recruitment difficulty across all treatment centers (and professions) were 'not interested in moving to our rural area' and 'can't offer competitive salary' respectively. Interestingly, ATC's appeared at least quantitatively, to have the least general difficulty in recruiting, possibly due in part to not seeing themselves as needing to recruit from psychiatric and nursing disciplines, and/or the possibility that they may have a more natural recruitment pool from their own client base (e.g. recovered substance users turned professional clinicians). The open-ended commentaries elaborate on the nature of professional shortages, competition with non-behavioral health fields (especially in relation to nurses), and indicators of impoverished systems of care being a disincentive to new recruits.

Current Methods of Recruitment

Method

Centers were asked to provide staffing levels and estimate annual expenditures, and list top methods devoted to recruitment for open positions. Centers were also asked if their recruitment approaches involved some form of connection with Indiana-based professional training/educational institutions.

Results

Human Resources Allocated to Recruitment

Total FTE's of dedicated HR/Recruitment staffing:

	Mean	SD
CMHCs	1.14	1.47
Hospitals	0.58	0.4
ATCs	1.83	4.50

Average annual expenses (last 5 years) for marketing and recruiting for open positions:

	Mean	SD	Min	Max	(Means x N)
CMHCs (N=27)	\$57,222	\$65,000	\$0	\$300,000	\$1,544,944
Hospitals (N=6)	\$55,083	\$68,038	\$1,500	\$182,000	\$330,498
ATCs (N=12)	\$5,250	\$14,235	\$0	\$50,000	\$63,000
				TOTAL	\$1,938,492

Top methods of Recruitment

- 1) Internet job postings (52 responses)
- 2) Staff referral/word of mouth (36 responses)
- 3) Newspapers (30)
- 4) Headhunters (20)

5) Job fairs (11)

% reporting recruitment involves regular contact with educational institution:

CMHCs	85%
Hospitals	100%
ATCs	75%
Other (community health centers)	63%

Summary/Interpretation

There was considerable variance among centers in number of recruitment staff and expenditures made in recruitment, likely due to the variance in size among these centers. Hospitals reported less HR staffing for recruitment as the state takes on significant portions of this role on their behalf. Estimated annual expenditures dedicated to statewide recruitment were substantial, on the order of \$2 million. A high number of all centers reported connectivity with training/educational institutions in their recruitment, with greatest advantage at hospitals, and least at public health centers.

Potential Solutions to Recruitment Problems

Method

Centers were asked to rate each of 7 possible provided solutions to ongoing recruitment problems on a 1 to 3 scale as (1) very helpful; (2) somewhat helpful and (3) not helpful. The ranking of these scores according to treatment center type are listed below. Each of the possible solutions is paraphrased here from their original form in the survey. Centers were then asked to elaborate with open ended responses in suggesting solutions for recruitment difficulties.

Results

CMHCs

RANK	SOLUTION	SCORE
1	Offer job-related incentives (e.g., professional education loan repayment)	1.22
2	Increase Indiana’s home grown pool of professionals	1.26
3	Devise new mechanisms of continuing education and promotion	1.67
4	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.78
5	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.89
6	Facilitate greater connectivity of centers with educational institutions	2.04
7	DMHA should provide centralized help in recruitment	2.37

State hospitals

RANK	SOLUTION	SCORE
1	Offer job-related incentives (e.g., professional education loan repayment)	1.00
2	Increase Indiana’s home grown pool of professionals	1.33
3	Devise new mechanisms of continuing education and promotion	1.5
4	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.5
5	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.5

RANK	SOLUTION	SCORE
6	Facilitate greater connectivity of centers with educational institutions	1.67
7	DMHA should provide centralized help in recruitment	2.17

ATCs

RANK	SOLUTION	SCORE
1	Offer job-related incentives (e.g., professional education loan repayment)	1.5
2	Increase Indiana’s home grown pool of professionals	1.67
3	Devise new mechanisms of continuing education and promotion	1.75
4	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.83
5	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.92
6	Facilitate greater connectivity of centers with educational institutions	2.33
7	DMHA should provide centralized help in recruitment	2.5

Open ended responses:

The following categories were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

- Address problems with benefits packages or perks
- Address problems with recruitment in rural areas:
- Address problems with overly complicated rules of credentialing, licensure, etc
- Address problems with recruitment methodologies
- Support recruitment through supporting educational missions:
- Need better pay across disciplines:
- Professional Resource Sharing

Summary/Interpretation

Offering of job-related incentives (e.g. loan repayment programs) was quantitatively viewed across centers as the best solution to recruitment problems. This may be seen as the most efficient way to increase the pool of new applicants, previously rated as the most comprehensive problem in recruitment. Similarly, directly tackling this problem via increasing Indiana’s home grown pool of professionals was also rated second most highly for CMHC’s and ATCs. The notion of facilitating greater connection between the centers and educational institutions was not ranked particularly high, possibly due to the centers already feeling like they have established connectivity with these institutions. However, in the open-ended responses, it seemed clear the centers wish for more support for taking on training missions within their own walls. The idea of DMHA taking on centralized authority in recruitment for the centers was consistently viewed unfavorably, possibly due to a suspicion of centralized government power and/or inability of DMHA to attend to local/specific needs. However, the idea of DMHA supporting a central website listing both job openings and applicants available to all DMHA supported centers was suggested in the open ended responses.

As a whole, the open-ended responses elaborated on a wide range of problems which need to be addressed in recruitment. One of the most frequent themes was the need for better pay in proportion to the work loads, which

was not a solution directly suggested in the quantitative portion of this survey. Personnel sharing was proposed as a method to spread expertise of psychiatrists over a broader area (or number of centers), although a barrier to this may be the inability of centers to provide health benefits to such shared or part time employees. Addressing problems with overly complicated rules of licensing and credentialing, was a major theme that seems related to calls for both ending the segregation of professional expertise along addictions vs. mental health care lines, and a need for allowing centers to more directly take on educational missions for trainees.

Retention Difficulties

Method

Retention was addressed as an issue independent from issues in recruitment and general need for professional types. Difficulty in retaining personnel as employees was ranked from 1 (most difficult); 2 (moderately difficult); 3 (easiest) among 13 professional types across all surveyed centers. From those professional types ranked as 1 (most difficult) to retain, centers were asked to choose up to 3 of 6 pre-provided reasons for these retention difficulties. Finally, centers were asked to elaborate with open ended responses on reasons for retention difficulties.

Results

CMHCs

Top five most difficult to retain positions:

PROFESSIONAL TYPE	MEAN SCORE
1. Case Managers, Bachelors or Associates	(1.92)
2. Behavioral Health Technician, HS diploma	(1.96)
3. Social Workers, Masters (LCSW)	(2.0)
4. Nurses	(2.19)
5. Psychiatrists	(2.41)

Top 3 reasons selected for difficulty in retaining:

Case Managers, BS or Associates:

Three-way tie:

- 1) professional frequently experiences 'burnout' (5 responses)
- 1) professional role is seen as a 'stepping stone' (5 responses)
- 1) center de-funding/increasing case loads destroys job satisfaction (5 responses)

Behavioral Health technician, HS diploma

- 1) professional, once hired, not prepared or educated for role (5 responses)
- 1) professional role is seen as a 'stepping stone' (5 responses)

2) professional frequently experiences 'burnout' (4 responses)

Social Workers, Masters

1) center de-funding/increasing case loads destroys job satisfaction (7 responses)

2) professionals expect more raises/promotions than we provide (5 responses)

2) professional frequently experiences 'burnout' (5 responses)

State hospitals (N=6)

Top five most difficult to retain positions:

PROFESSIONAL TYPE	MEAN SCORE
1. Nurses	(1.67)
2. Behavioral Health Technician (HS diploma)	(1.67)
3. Psychiatrists	(2.00)
4. Pharmacists	(2.17)
5. Social Workers, Masters	(2.33)

Top 3 reasons selected for difficulty in retaining:

Nurses

1) professional frequently experiences 'burnout' (3 responses)

2) personal problems that interfere with reliability/professionalism (2 responses)

2) center de-funding/increasing case loads destroys job satisfaction (2 responses)

Behavioral Health Technician (HS diploma)

1) personal problems that interfere with reliability/professionalism (3 responses)

1) professional, once hired, not prepared or educated for role (3 responses)

3) professional frequently experiences 'burnout' (2 responses)

Psychiatrists

Only one reason was suggested

1) professionals expect more raises/promotions than we provide (1 response)

ATCs (N=12)

Top five most difficult to retain positions:

PROFESSIONAL TYPE	MEAN SCORE
1. Substance Abuse Counselors (Associates or Bachelors)	(2.58)
2. Social Workers, (Masters, LCSW)	(2.58)
3. Mental Health Clinician (Masters level (LMFT, LMHC))	(2.58)
4. Case Manager (Associates or Bachelors)	(2.67)
5. Substance Abuse Counselors (Masters)	(2.67)

Top 3 reasons selected for difficulty in retaining:

Substance Abuse counselors (Associates or Bachelors)

No reasons were specified.

Social Workers, (Masters, LCSW)

- 1) professional frequently experiences ‘burnout’ (2 responses)
- 2) three way tie (1 response each): professional role is seen as a ‘stepping stone’; professionals expect more raises/promotions than we provide; center de-funding/increasing case loads destroys job satisfaction

Mental Health Clinician (Masters level (LMFT, LMHC))

Two way tie for first only (1 response each)

- 1) professional frequently experiences ‘burnout’
- 1) professionals expect more raises/promotions than we provide

Open ended responses:

The following categories were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

- Turnover is actually not a problem in and of itself at our center
- Nature of Burnout and job dissatisfaction
- No mechanisms for merit based promotions or perk

Summary/Interpretation

In comparison to recruitment difficulties, retention problems appear to present differently qualitatively and in severity. In contrast to recruitment problems which appeared to weigh heavier in higher educated professionals, retention problems impact lower educated positions most severely. Also, the severity of overall retention problems may be less of a problem than overall recruitment because 1) severity scores for leading problem professionals mentioned were less extreme for retention than recruitment; 2) centers may see lack of retention in certain cases as

a natural mechanism of either individuals progressing along career paths, or weeding out incompetence; and 3) in the open-ended responses, several centers reported that retention was not a major problem. Nevertheless, many centers listed several non-prescribing professional types (nurses and masters level professionals) as significant retention problems citing job dissatisfaction and burnout as important causes. Impoverished clinical resources along with too large caseloads were frequent concerns in the open-ended statements along with statements describing the high degree of documentation and paperwork that impedes contact time with clients.

Future Challenges

Method

Centers were asked to provide open-ended descriptions of concerns not already covered by the survey that are seen as significant future challenges to their workforce integrity and clinical missions. The following responses were selected and paraphrased from the total pool of open-ended responses. These have been listed according to recurrent themes evident in the response patterns.

Results

The following categories were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

- Emerging problems with licensing of professionals
- Need cross training of professionals/combat services in silos
- Aging workforce
- Will generally need higher education for the workforce
- Worsening systems dysfunction
- Generalized Fear about the economy and health care reform

Section Summary

The recruitment and retention survey of 2009 confirmed findings from the 2007 DDPAT survey suggesting that behavioral health care in Indiana is facing a general crisis of psychiatric physician supply, especially of child and addiction psychiatrists. In addition, however, the 2009 survey also indicated a concurrent crisis relative to a much broader array of behavioral health professionals, including nurses and masters levels clinicians (e.g. social workers and therapists). Taken together, these findings suggest a generalized inadequacy in the behavioral health workforce that may most directly result from the inadequate supply of new professionals trained in these fields. Retention appeared to be less of a problem, especially for professionals with high educational attainment, although certain positions (e.g. nurses) do represent a problem. Feedback from the centers depicts a rather grim picture of workforce conditions in public behavioral health related to the interactive effects of chronic de-funding and worsening economic difficulties, problems with morale, stigma (suffered by both the clients and the professionals who provide care), and the highly regulated/documentation based culture of behavioral care which distracts from client contact, and ironically quality of care and productivity. It should be noted that feedback about workforce conditions came not from the clinicians who are directly impacted, but by the administrative leadership of centers who represent them.